EFFECTIVENESS OF FAMILY PSYCHO EDUCATIONAL INTERVENTION ON CAREGIVER BURDEN AMONG PRIMARY CAREGIVER OF SCHIZOPHRENIA CLIENTS ADMITTED IN GOVERNMENT RAJAJI HOSPITAL AT MADURAI.

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CERTIFICATE

This is to certify that this dissertation titled**,** "**EFFECTIVENESS OF FAMILY PSYCHO EDUCATIONAL INTERVENTION ON CAREGIVER BURDEN AMONG PRIMARY CAREGIVER OF SCHIZOPHRENIA CLIENTS ADMITTED IN GOVERNMENT RAJAJI HOSPITAL AT MADURAI"** is a bonafide work done by **Mrs. V.SUMATHI,** M.Sc. (N) Student, College of Nursing, Madurai Medical College, Madurai - 20, submitted to the TAMILNADU DR. M.G.R. MEDICAL UNIVERSITY, CHENNAI in partial fulfillment of the university rules and regulations towards the award of the degree of **MASTER OF SCIENCE IN NURSING**, **Branch V, Mental Health Nursing**, under our guidance and supervision during the academic period from 2012—2014.

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ABSTRACT

Title - Effectiveness of family psycho educational intervention on caregiver burden among primary caregiver of schizophrenia clients in Government Rajaji Hospital at Madurai.

Objectives - To assess the pretest level of caregiver burden among primary caregiver of schizophrenia clients admitted in psychiatry ward at Government Rajaji Hospital, Madurai. To evaluate the effectiveness of Family psycho educational intervention among the primary caregiver of schizophrenia clients admitted in psychiatry ward at Government Rajaji Hospital, Madurai.To associate the post test level of caregiver burden among the primary caregiver of schizophrenia clients with their selected socio demographic variables. The conceptual frame work for this study was based on **Imogene M. King's "Transaction model"** This study is Pre experimental (one group pre test- post test) design. The research approach used for this study is quantitative approach. This study consists of post test, psycho education intervention and post test method**.** This study will aim to assess the level of caregiver burden among primary caregiver of schizophrenia client in selected psychiatry ward, Govt. Rajaji Hospital, Madurai. The family psycho educational intervention could help the primary caregiver of schizophrenia clients to promote adequate knowledge regarding importance of communicate and skills-way to express emotion, relaxation methods towards family psycho educational intervention The data collection period was for 6 weeks from 01.9.2013 to 15.10.2013. The investigator divided the 60 caregiver in to four groups among each group have 15 caregiver .Following the assessment, one week of family psycho educational intervention was administered for each group All the subjects were makes attend the family psycho educational intervention disease,

treatment and drug compliance, Reducing relapses, Re-hospitalization, communication and problem solving skills, effective way to express emotion, Family psycho educational intervention was given Every day for 45minutes for six consecutive days by group discussion. After 6^{th} day the whole content was summarized then post test was conducted on 6^{th} Day to assess the caregiver burden using the same scale.. The mean post test care givers burden was reduced from 43.4 to 37. at 0.05% level of significance.

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CHAPTER - I

INTRODUCTION

'Education is the most powerful weapon which you can use to change the world'

- Nelson Mandela

Family is a major health enhancing resource with each member doing his or her very best to maximize pleasant and minimize unpleasant events in the family unit and the immediate social environment. Hence, a family member developing an illness can be an upsetting situation especially when it is mental illness. A vast majority (66%) of caregiver in India are found depressed and anxious because of their client's illness.

According to WHO, nearly a quarter of the global population is suffering from mental health problems in a way or other? In India the prevalence of psychiatric disorders is 58.2/1000 population which means 5.7 crore Indians are suffering from some sort of psychiatric disturbance; out of this, 1.5 crore people are suffering from severe mental illness. Many people still do not understand that mental health issues in general population affect all of us, whether we are suffering from mental illness or not; it can even affect one of our family member.

Schizophrenia is a disruptive and distressing illness, for the people affected and their family members. Similar to the United States , Schizophrenia is a disabling group of brain disorders characterized by symptoms such as hallucinations, delusions, disorganized communication, poor planning, reduced motivation, and blunted affect (**McGrath, Saha, Welham, Saadi, MacCauley & Chant, 2004**).

Over one-third of people with schizophrenia in Hong Kong live with their families, and they often depend on a family member's assistance and involvement in providing care at home. However, these family members are often inadequately prepared to be the main caregiver for the ill relative . Studies have indicated that there is a severe burden imposed upon the whole family when caring for a member with schizophrenia, because of unpredictable and bizarre behavior, external stressors of stigma and isolation, family conflict, emotional frustration and burnout. With the current emphasis on community care for mentally ill patients, family intervention, especially using a diverse range of modalities and a group format, could satisfy the informational needs of family, and develop a variety of coping strategies ensuring effective care is provided for a relative with schizophrenia, and thus patient relapses are ultimately reduced . Although there have been a few theoretical and psychological models of commonly used family group interventions, empirical studies seeking to explain which model is most effective have been inconsistent. Two recent systematic reviews of family interventions in schizophrenia suggest that a few psychological models, such as family psycho educational intervention family groups and behavioral family management, reduce patient relapse and readmission but not family distress and burden. In have included Hispanics and Asians

There are also only a limited number of studies focusing on Chinese populations, even though they may be more likely to be affected by their interactions with family members. Therefore, it is unclear whether interventions that have been established as effective in Western countries can be applied successfully to a Chinese family culture. This study sets out to systematically find an effective model of intervention for Chinese families caring for a mentally ill member. family is a major health enhancing resource with each member doing his or her very best to maximize

pleasant and minimize unpleasant events in the family unit and the immediate social environment. Hence, a family member developing an illness can be upsetting especially when it is mental A vast majority (66%) of caregiver in India are found depressed and anxious because of the patient's illness.

Client stressors such as negative and disruptive symptoms have been linked to increased burden in caregiver of patients with schizophrenia. Wine field and Harvey (1993) found a significant positive correlation between the level of behavioral disturbance in the patient and caregiver' distress. However, one study found no link between these patient stressors and family burden.

Saldanha (1994) explains about the role played by one family member; and his health status can influence the health and functioning level of the rest of the family. When a member is Sick he would discontinue from his normal social activities. So the other family members have to undertake the care of the sick person. One person's poor social performance is another person's burden

Caregiver are "the people who provides care to the person who had illness and cannot perform day to day activities". Caring for loved one with Schizophrenia possess many challenges to the families and caregiver. Family caregiver of people with often Schizophrenia are called as the invisible second patient who are critical to the quality of life of the care recipients. The effects of being a family caregiver, though sometimes positive, are generally negative, with high rates of burden and psychological morbidity as well as social isolation, physical ill- health and financial burden. Care givers are vulnerable to adverse effects like overburden, depression, and stress. Numerous studies report that caring for a person with is more Schizophrenia stressful than caring for person with a physical disability.

Caregiver plays a critical role in all stages of care for persons with including Schizophrenia diagnosis, treatment and management. Providing care for a person with faces Schizophrenia many challenges both mentally and physically such as depression, anger, frustration, fatigue, isolation, financial burden, excessive stress, irritability and relationship conflicts often these challenges affects the caregiver.

Care giver burden and expressed emotion are too different constructs that may be related. Care givers of Schizophrenia clients have high levels of expressed emotions including critical, hostile, or over involved attitudes

According to WHO, nearly a quarter of the global population is suffering from mental health problems in a way or other. In India the prevalence of psychiatric disorders is 58.2/1000 population which means 5.7crore Indians are suffering from some sort of psychiatric disturbance; out of this, 1.5crore people are suffering from severe mental illness. Many people still do not understand that mental health issues in general population affect all of us, whether we are suffering from mental illness or not; it can even affect one of our family member.

Sharif (1992) family psycho educational intervention is an important component of any psychotherapy program. Family psycho educational intervention , as the name suggests, is education about a certain situation or condition that causes psychological stress. There are many ways to combat psychological stressors, one is learning about the condition. Once a person better understands a condition they feel more in control of the situation and this in turn reduces the stress associated with it. Family psycho educational intervention is usually implemented by a psychologist or anybody who is an expert in the specific condition the individual is experiencing and who has experience in psychotherapies.

Family psycho educational intervention is among the most effective of the evidence-based practices that have emerged in both clinical trials and community settings. Because of the flexibility of the model, which incorporates both illness-specific information and tools for managing related circumstances, family psycho educational intervention has broad potential for many forms of illnesses and varied life challenges. **Wai Tong Chien (2008)**

Family psycho educational intervention can be implemented in a number of different formats and settings. The format depends entirely on the disorder, the developmental age of the Individual and their individual needs. Family psycho educational intervention can be group-based, family-based, parent-based or individually implemented. Family psycho educational intervention most commonly involves the individual with the disorder, the patient or client, but in some situations family psycho educational intervention is implemented only to the people who deal with the patient on a day to day basis such as family, friends, teachers or caretakers **A. Harrison (2009)**

Family psycho educational intervention for any person that is experiencing psychological Stressors and hardships due to a condition is vital. It is everybody's right to have information regarding their condition and therefore, no matter what their cognitive or psychological state, a degree of family psycho educational intervention must be administered to everyone. If some education must be taught without the affected person present this should always be accompanied with a similar program for them so they are not left in the dark. These cases occur when the education required for the affected person needs to be delivered at a different level and incorporate

different information than for the people who care for them. This is mainly the case for very young children and for schizophrenia clients given by **Gulseren.L,**

Family psycho educational intervention can take a various amount of sessions before it is complete, this depends on how well the concepts and learning outcomes are achieved. In order to maximize the efficiency of the program the psychologist will deliver the content that is most appropriate for their client or clients in an interesting way. Family psycho educational intervention should not be too hard to understand, nor should it go so slowly that it is boring. If you are finding the family psycho educational intervention is not appropriate for you or your family share this with your psychologist and perhaps they can change their content or teaching patterns. Family psycho educational intervention is rarely classroom-type teaching. It involves interactive learning such as role plays, reading, writing, DVDs and discussion by **Christiane (2010)**

1.1NEED FOR THE STUDY

Schizophrenia was coined in 1908 by Eugene Bleuler. Schizophrenia is a psychotic condition characterized by a disturbance in thinking, emotions, volitions and faculties in the presence of clear consciousness, which usually leads to social withdrawal. Schizophrenia is the most common of all psychiatric disorders and is prevalent in all cultures across the world. About 3 to 4 per 1000 in every community suffer from schizophrenia. It is equally prevalent in men and women. The peak ages of onset are 15 to 25 years for men and 25 to 30 years for women

GLOBAL SCENARIO OF SCHIZOPHRENIA:

The World Health Organization (2013) statistical report stated that currently 35.6 million people are living with Schizophrenia . It will double by 2030 and then triple by 2050

AGE	**60 – 64 yrs**	**65 – 69 yrs**	**70 – 74 yrs**	**75 – 79 yrs**	**80 – 84 yrs**
West Europe	1.2	1.9	3.8	7.0	13.6
South America	0.9	1.9	3.8	7.7	15.8
Middle East	0.9	1.8	3.5	6.6	13.6
Japan	1.5	1.6	3.3	6.4	14.1
Australia	0.9	2.3	2.8	5.8	21.4
China	0.7	1.8	2.6	4.7	10.4
India	0.8	0.9	1.8	3.7	8.2

The World Health Organization report also stated that 65.7 million caregiver providing care to the clients Schizophrenia in that 66% caregiver were females, 51% of caregiver were between the age of 18 to 40 years. Majority of the care recipients reside in their own home **(WHO 2012)**

It was estimated that on a global basis there are 4 – 6 million new cases of every year (about one new cases every 7 seconds) and number of people living with projected Schizophrenia to double every 20 years.**(Census Study 2010)**

INDIAN SCENARIO ON SCHIZOPHRENIA

Setting	Location	Prevalence (%)
Urban	Chennai	0.9% for age >65yrs
	Kochi	3.3% for age >65yrs
	Kolkata	1% for age >60yrs
	Mumbai	2.3% for age >65yrs
	Trivandrum	4.8% for age >65yrs.
Rural	Ballabgarh (Delhi)	1.1% for age >65yrs
	Ernakulam (Kerala)	3.1% for age >65yrs
	Vellore (Tamil Nadu)	3.5% for age>60yrs

Epidemiological studies were conducted in India and report stated that 3.7 million people aged over 60yrs have Schizophrenia (2.1 million women and 1.5 million men).The prevalence of Schizophrenia increased steadily with age and higher prevalence was seen among older women than men. The younger age groups of 60 – 75 years are expected to increase steadily over time. **(ARDSI 2010)**

Incidence data on Schizophrenia from India is limited; a study conducted on rural region like Haryana and Ballabargarh reported on 3 – 24 million incidence rate per 10,000 population.

A meta analysis on prevalence of Schizophrenia estimated that by 2026 more than 500,000 older people dementia are expected to be living in Uttarpradesh and Maharashtra. **(ARDSI 2010)**

In other states (Rajasthan, Gujarat, Bihar, West Bengal, Madhya Pradesh, Orissa, Andhra Pradesh, Karnataka, Kerala and Tamil Nadu) around 20,000 to 40,000 persons with Schizophrenia are expected to be diagnosed within the next 26 years.

The family members may show varying attitude towards mental illness and the mentally ill family member according to their level of knowledge and experience regarding mental illness. Despite the increased publicity surrounding the mental illness issues there is still lack of understanding about mental illness.

"The Camp Approach" started in 1958 by Dr Vidhya Sager, Professor and Head of Department of Psychiatry at Amritsar helped in removing the stigma associated with mental illness. He put up tents in hospital camps and entrusted nursing care to the family members who stayed with them. Thus families were more involved in the treatment as they were the main caregiver which led to new therapeutic modality, the Family psycho educational intervention .

Thus, family psychiatric units were formed with a view to involve the family members to stay with the mentally ill clients in the hospital settings and take part in the basic care since family members act as the main caregiver. General Hospital Psychiatric Units (GHPU) were also formed as part of family therapy. This approach is practiced in developed countries and is slowly emerging in developing countries like India. In such settings the primary caregiver participate in providing basic care, supervise medication intake, and provide social, emotional and financial support to the patient and this is proving effective when compared to those settings in which the

mentally ill clients are allowed to stay alone without their family members. In the former, the incidence of relapse and drug compliance is more.

A comparative study on conjoint family therapy and separated family therapy showed that after a 5-year follow-up, 75 percent had good outcome, 15 percent had intermediate, and 10 percent had poor outcome. But most of the primary caregiver do not possess adequate knowledge and attitude towards family involved therapy in general.

Since the 1980s, several studies have demonstrated the efficacy of these interventions. In patients whose families received them, the relapse rate at one year ranged from 6 to 12%, compared with 41 to 53% in routine management care groups. At two years, the relapse rates were 17 to 40% and 66 to 83%, respectively. Recent meta-analyses confirmed that family interventions, compared with routine case management, reduce patients' relapse rate fourfold at one year, and twofold in the subsequent year. In addition, family interventions have been found to improve patients' compliance to antipsychotic drug treatments, and to reduce the overall economic costs of care.

Family psycho educational intervention refers to the education offered to people who live with a psychological disturbance. During family psycho educational intervention, the patient is provided with knowledge about the psychological condition, the causes of that condition, and the reasons why a particular treatment might be effective for reducing their symptoms. Family psycho educational intervention is most commonly part of cognitive behavioural therapy, but it can also be provided during other types of psychotherapy. Since it is often difficult for the patient and their family members to accept the patient's diagnosis, family psycho

educational intervention also has the function of contributing to the de-stigmatization of psychological disturbances and to diminish barriers to treatment. Through an improved view of the causes and the effects of the illness, family psycho educational intervention frequently broadens the patient's view of their illness and this increased understanding can positively affect the patient. The relapse risk is in this way lowered; patients and family members, who are more well-informed about the disease, feel less helpless. A study conducted to assess the effects of family psycho educational intervention al compared to the standard levels of knowledge provision. All relevant randomized controlled trials focusing on family psycho educational intervention for schizophrenia and/or related serious mental illnesses involving individuals or groups. Quasi-randomized trials were excluded. Data were extracted independently from included papers by at least two reviewers. Authors of trials were contacted for additional and missing data.

Relative risks (RR) and 95%confidence intervals (CI) of homogeneous dichotomous data were calculated. A random effects model was used for heterogeneous dichotomous data. Where possible the numbers needed to treat (NNT) were also calculated. Weighted or standardized means were calculated for continuous data. Any kind of family psycho educational intervention al intervention significantly decreased relapse or readmission rates at nine to 18 months follow-up compared with standard care (RR 0.8 CI 0.7-0.9 NNT 9 CI 6-22). Evidence from trials suggests that family psycho educational intervention al approaches are useful as a part of the treatment programme for people with schizophrenia and related illness. The fact that the interventions are brief and inexpensive should make them attractive to managers and policy makers. More well-designed, conducted and reported randomized studies investigating the efficacy of family psycho educational intervention are needed.

There are hardly any randomized-controlled trials of structured family interventions for schizophrenia from India. family psycho educational intervention study attempted to evaluate the impact of a structured family psycho educational intervention for schizophrenia, compared with standard outpatient treatment, on various patient- and caregiver-related parameters. 76 patients with schizophrenia and their caregiver were randomly allocated to receive either a structured family psycho educational intervention (n = 38) consisting of monthly sessions for 9 months or 'routine' out-patient care (n = 38) for the same duration. Psychopathology was assessed on monthly basis. Disability levels, caregiver-burden, caregiver-coping, caregiver-support and caregiver-satisfaction were evaluated at baseline and upon completion. Structured family psycho educational intervention was significantly better than routine out-patient care on several indices including psychopathology, disability, caregiver-support and caregiver-satisfaction. The family psycho educational intervention package used was simple, feasible and not costly. Structured family psycho educational intervention is a viable option for treatment of schizophrenia even in developing countries like India.

The different models of family psycho educational intervention share the general goals of reducing relapses and improving the quality of life of patients and their family members by: providing the whole family with information about diagnosis, symptoms, signs, etiology, course and treatment, including medications and the management of their side effects; improving communication patterns within the family; enhancing the family's problem-solving and coping strategies; encouraging relatives' involvement in social activities outside the family; and focusing on the management of practical daily issues. The models mainly differ in program elements, including: the location of service provision (i.e., home, clinic, outpatient unit and

hospital); the length of the intervention; the type of involved professionals; the content emphasized and the information provided; the focus on problem-solving, communication skills or behavioral management; the use of a single versus multiple-family approach; the involvement of relatives; and the way the information is delivered.

In spite of the evidence of their efficacy, family psycho educational intervention family interventions are not commonly applied in clinical practice. In a study carried out in several European countries, the proportion of families who had ever received a family psycho educational intervention al intervention ranged from 0 to 15% .Studies which have attempted to introduce these interventions into routine clinical settings reported that only 7 to 27% of trained staff put the skills learnt into practice ,and that the average number of families seen by each therapist in the year after the training ranged from 1.4 to 1.7 .One of the factors influencing the dissemination of these interventions in mental health services has been found to be the availability of training courses and supervision for the staff .

The original trial of the Clinician-Based Cognitive Family psycho educational intervention for Families involved over 100 families randomized to two active conditions (group discussions or the family talk intervention) in Boston, Massachusetts; after 4.5 years sustained effects were seen in both groups. Another randomized trial was conducted with low-income, single-parent mothers in Dorchester, Massachusetts, and an open-trial replication were conducted with Latino families at Children's Hospital in Boston. Clinician-Based Cognitive .

Family psycho educational intervention for Families has been implemented in Holland as a regular part of prevention practice with two 2-day training seminars every year. In Finland, the approach has been employed for countrywide use, with over 650 clinicians and 80 master trainers trained since 2001. The intervention has been selected for countrywide implementation in Norway. Principles of the program have been used in Head Start and Early Head Start.

A study conducted to assess the effectiveness of a group psycho-educational program on family caregiver for patients with schizophrenia and mood disorders. This randomized controlled trial was performed on 100 caregiver for patients with mental disorders attending the Isfahan Behavioral Sciences Research Center (IBSRC), in Isfahan, Iran. One hundred family caregiver of patients with schizophrenia (n=50) and mood disorders (n=50) were selected and assigned randomly to either a psycho-educational group intervention or routine care in each diagnosis category. The caregiver were followed for 3 months. Caregiver burden was assessed significantly for the group that participated in the psycho-educational program, while scores in the control group did not change significantly. This group disorders in the Iranian population. This group intervention program may improve the quality of life of patients and caregiver by improving the standards of care giving.

1.2 STATEMENT OF PROBLEM

"A Study to assess the effectiveness of family psycho educational intervention on caregiver burden among primary caregiver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai."

1.3 OBJECTIVES OF THE STUDY

1. To assess the pretest level of caregiver burden among primary caregiver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai.
2. To evaluate the effectiveness of Family psycho educational intervention among the primary caregiver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai.
3. To associate the post test level of caregiver burden among the primary caregiver of schizophrenia clients with their selected socio demographic variables.

1.4 HYPOTHESES

H_1 There is a significant difference between the pretest score and post test score of family psycho educational intervention on caregiver burden among primary caregiver of schizophrenia Clients.

H2 : There is a significant association between the post test level of caregiver burden with their selected socio demographic variables

1.5 OPERATIONAL DEFINITION:

Effectiveness:

In this study it refers to the outcome of family psycho educational intervention and its caregiver burden of primary caregiver of schizophrenia clients as measured by caregiver burden scale.

Family psycho educational intervention

In this study, it refers to the items listed in the structured interview and educating schedule, in order to elicit the primary caregiver response on increasing patient and family knowledge about disease, better adjustment illness, Treatment and Drug compliance., Reducing relapses, Re-hospitalization, communication and facilitating problem solving skills, effective way to express emotion, relaxation methods.

Primary caregiver;

In this study caregiver refers to the family members of the schizophrenia clients who are with the clients and taking care of them regularly

Schizophrenia:

In this study it refers to individuals who are diagnosed and admitted in psychiatry ward, Government Rajaji Hospital, Madurai.

1.6 ASSUMPTION

The investigator assumes that;

- Primary caregiver may have varying levels of Burden while caring for a patient with schizophrenia.
- Assessing the caregiver burden level may enhance their foster favorable communication level to Family psycho educational intervention
- Understanding disease condition, problem solving skills among caregiver may reduce the caregiver Burden.

1.7 DELIMITATION

- This study was imited to only the care giver of schizophrenia clients admitted at Government Rajaji Hospital only.
- Data collection period was delimited to 6 weeks.

1.8 PROJECTED OUTCOME

This study will aim to assess the level of caregiver burden among primary caregiver of schizophrenia client in selected psychiatry ward, Govt. Rajaji Hospital, Madurai. Causes signs and symptoms, treatment and relapse, communication, facilitating problem solving, effective way to expressed emotion, relaxation methods towards the schizophrenia clients. Investigator assessing the effectiveness of family psycho educational intervention on caregiver burden. The family psycho educational intervention could help the primary caregiver of schizophrenia clients to promote adequate knowledge regarding importance of communication and skills and the way to express emotion, relaxation methods towards family psycho educational intervention .

CHAPTER –II

2.1 REVIEW OF LITERATURE

A review of literature is synthesis of what is known and not known

- **Nancy Burns and Susan K Grove**

LITERATURE RELATED TO CAREGIVER BURDEN AMONG SCHIZOPHRENIA

Review of literature is an essential task in the research process. It brings clarity to the research problem, and broadens the knowledge base in the research area.

Review of literature is a systematic identification, location, scrutiny and summary of written material that contain vital and essential information on the research problem.

Review of literature in this study is organized under the following sections.

Section-A Studies related to the caregiver burden among the primary caregiver of Schizophrenia clients.

Section-B: Studies related to the effect of family psycho educational intervention on caregiver

Section-C: Studies related to the effect of family psycho educational intervention on caregiver burden among the primary caregiver of schizophrenia clients.

LITERATURE RELATED TO THE CAREGIVER BURDEN AMONG THE PRIMARY CAREGIVER OF SCHIZOPHRENIA CLIENTS

Falloon and Pederson (2012) conducted a randomized controlled trial study to evaluate Depressive Disorders among caregiver of schizophrenic patients and its relationship with burden of care and perceived stigma Sixty primary caregiver of patients with schizophrenia, and 30 healthy non-caregiver as a control group. Both groups were screened for depressive symptoms using the Center of Epidemiological Studies for Depression Scale. Diagnosis of Depressive Disorders was made according to DSM-IV-TR criteria. The Caregiver Strain Index and the Discrimination-Devaluation Scale were administered to the caregiver. The results indicate that Depressive Disorders were higher among caregiver (18.33%) than control group (3.33%) with ($p < 0.05$). Depressive Disorders were correlated with burden of care and perceived stigma. Depressive symptoms were associated with increased number of hours per week for providing care, older age of the caregiver and duration of care giving.

Scheltens P (2011) conducted a cross – sectional study to evaluate the association between caregiver's burden and psychological distress and to estimate the prevalence of Schziophernia among the caregiver. 40 caregiver participated and assessed by Zarit Burden Scale and GHQ – 28 to evaluate psychological distress. Convenient sampling technique was used. The result of the study showed that 80.7% of caregiver had high level of burden

Chien,W.T., Norman,I. (2011) conducted a longitudinal study to assess the subjective burden of husbands or wives in the care of clients with Schziophernia. 158 caregiver participated and selected by convenient sampling technique. Zarit Burden Assessment Scale was administered to caregiver of clients with Schziophernia. The findings of the study revealed that among spouses, 62% of wives were having more burden than husbands.

Dr. Kam-shing Yip (2011) conducted a descriptive study to investigate the burden experienced by families providing care to a relative with Schziophernia 172 caregiver were participated in the study. Convenient sampling technique was used. Data collected by using Burden Interview Scale, Behaviour Memory Problem Checklist, Depression Scale and Ways of Coping Questionnaire. The results showed that 68.02% of caregiver were highly burdened and 65% of caregiver exhibited depressive symptoms.

McFarlane and colleagues (2010) conducted a cross – sectional study to evaluate the association between caregiver's burden and psychological dis**)** conducted a epidemiological study on identifying a target group depression among caregiver of clients with Schziophernia in Netherlands. 525 caregiver participated who were selected by convenient sampling technique. Depression scale was administered to the caregiver. The findings of the study revealed that 62% caregiver had increased risk for depression and psychological distress.

Aizcorbeurrozc Ashraf Ray(2010), conducted a randomized controlled trial study to evaluate Depressive Disorders among caregiver of schizophrenic patients and its relationship with burden of care and perceived stigma Sixty primary caregiver of patients with schizophrenia, and 30 healthy non-caregiver as a control group. Both

groups were screened for depressive symptoms using the Center of Epidemiological Studies for Depression Scale. Diagnosis of Depressive Disorders was made according to DSM-IV-TR criteria. The Caregiver Strain Index and the Discrimination-Devaluation Scale were administered to the caregiver. The results indicate that Depressive Disorders were higher among caregiver (18.33%) than control group (3.33%) with (p ‹0.05). Depressive Disorders were correlated with burden of care and perceived stigma. Depressive symptoms were associated with increased number of hours per week for providing care, older age of the caregiver and duration of care giving.

Chien,W.T., Norman,I. (2009) The effectiveness and active ingredients of mutual support groups for family caregiver of people with psychotic orders: Twenty-five research studies were selected for inclusion in the analysis on the basis that they were either family led or professional-facilitated support group programmes for family caregiver of people with schizophrenia or other psychotic disorders. The review identified that most studies on this group programme used qualitative, exploratory cross-sectional surveys and quasi-experimental study designs (ná=á19); six were experimental studies or randomised controlled trials. There were only a few small-scale, single-centre controlled trials with the findings supporting the significant positive effects of mutual support groups on families' and patients psychosocial well-being. A number of non-experimental studies conducted in Western countries reported benefits of group participation up to 1 year, such as increased knowledge about the illness, reduced burden and distress, and enhanced coping ability and social support. However, many of these studies lacked rigorous control and did not use standardised and valid instruments as outcome measures or schedule follow-up to

examine the long-term effects of support groups on families and/or patients at ($p < 0.05$)level

Christiane roick, dirk heider, (2006), conducted a comparitive study to analyse whether family burden is affected by national differences in the provision of mental health services. Patients with schizophrenia and their key relatives were examined in Germany (*n*=333) and Britain (*n*=170). Differences in family burden in both countries were analysed with regression models controlling for patient and caregiver characteristics. The total mean IEQ burden score of caregiver was 43.2 (s.d.=13.0) in Germany and 46.1 (s.d.=16.8; *P*=0.087) in Britain. Results indicate that family burden was associated with patients'symptoms, male gender, unemployment and marital status, as well as caregiver'coping abilities, patient contact and being a patient's parent. However, even when these attributes were controlled for, British caregiver reported more burden than German caregiver.

Christine A. Harrison, ((1988), conducted a cross - sectional study on caregiver burden in Schizophrenia. 322 ambulatory outpatients with a diagnosis of Schizophrenia, those caregiver were participated as sample who were selected by convenient sampling technique. Burden Interview, caregiver distress scale, was administered. The findings of the study revealed that 60% of caregiver had severe behavioural disturbances, and psychiatric symptoms.

Mark Dadds,((1988),conducted a descriptive study to examine Relationships between patients' negative symptoms, family caregiver' knowledge of schizophrenia, caregiver' attributions about the cause of patients' symptoms, and caregiver' response to the symptoms among the sample of 84 caregiver of patients with schizophrenia in Brisbane, Australia, Patients were assessed using the Positive and Negative Syndrome

Scale (PANNS),were interviewed using a structured format and measures designed for the study, Results of regression analyses indicated that three variables significantly predicted caregiver' criticism of patients—a smaller proportion of negative symptoms in the patient's overall symptom pattern, the caregiver's low level of knowledge about the illness (R=.42, R2=.18, F=5.69, df=3,80, p<.01)., and the caregiver's attributing the cause of negative symptoms to the patient's personality rather than to the illness.

LITERATURE RELATED TO THE EFFECT OF FAMILY PSYCHO EDUCATIONAL INTERVENTION ON CAREGIVER BURDEN.

Rosenheck R (2009)aimed to teach families effective problem-solving and communication skills. An individualized assessment of each family's needs and strengths was first conducted. In-home sessions, which included the patient, initially provided education, but then focused on problem-solving skills. Multifamily groups were conducted at the hospital after the first 9 months of in-home sessions. The study randomized 36 schizophrenia patients living with high-EE families to family or individual management and provided 9- and 24-month followups. Patients in the family therapy group had significantly lower relapse rates. (At 9 months: 1/18 family patients and 8/18 individual patients relapsed; $p < 0.01$).

Nils Berglund, (2008), studied 103 schizophrenia patients with at least one high-EE relative who were randomized to receive social skills training and family psychoeducation, social skills training only, family psychoeducation only, and medication only. The family treatment sequentially focused on building an alliance with the family; providing concrete information and management suggestions and building a support network with other families at a 1-day survival skills workshop; and applying workshop skills in individual family therapy with the patient included.

At a 2-year followup of those who received treatment, 25 percent of patients receiving both psychosocial treatments had relapsed, 29 percent of patients receiving family treatment had relapsed, and 62 percent of patients in the control group had relapsed, showing a significant family treatment effect ($p < 0.01$).

Scheltens P (1995) studied 83 schizophrenia inpatients who had lived with a relative for 3 months before admission and who intended to return to live with that relative. Patients from families with high-EE were randomized to behavioral treatment (enactive and symbolic), education only, and routine treatment. Patients from families with low-EE were randomized into education only and routine treatment cells. After 2 years, 33 percent of patients in behavioral treatment groups had relapsed compared with 59 percent from the high-EE control group and 33 percent from the low-EE control group. Follow ups of patients at 5 and 8 years showed persistently lower relapse rates for patients who received the family intervention. At 5 years, the relapse rate in the intervention condition was 13 out of 21 patients (62%); in the control condition it was 20 out of 24 patients (83%). Comparable relapse rates at 8 years were 14 out of 21 patients (67%) and 21 out of 24 patients (88%) for the same groups, respectively.

Mari and Streiner (1994) conducted a meta-analysis of the effect of family interventions on relapse evaluated the effect of family interventions on relapse in two analyses. In the first, they included only subjects who completed the interventions. In the second, they conducted an "intent-to-treat" analysis, including all subjects who were referred. For this analysis, they made conservative assumptions; all patients lost to followup in the experimental condition were assumed to have relapsed, and all patients in the control condition were assumed not to have relapsed. The total number

of patients included in the six trials was 350 (181 in the control group and 169 in the experimental group). Pooled data of those who completed the study showed that family intervention had a significant effect on the reduction of relapse at followups at 6 months ($p < 0.05$).

McFarlane and colleague s (1994) attempted to replicate their pilot study comparing psychoeducational multifamily and single-family groups in a six-site randomized trial -- the New York State Family Psychoeducation in Schizophrenia Project. A total of 172 DSM-III-R (American Psychiatric Association 1987) schizophrenia patients at six New York State public hospitals with broad geographic repostsentation were randomly assigned to single- or multiple-family psychoeducational treatment. Patients were living with their family of origin or had at least 10 hours per week of family contact. Authors emphasized that the intervention was not conducted in a protected research environment and was offered to a less restricted and more typical sample of schizophrenia patients. Families in both conditions were assigned to a family clinician who was a case coordinator, educator, group leader, and liaison. Eligible subjects also had to attend at least three treatment engagement sessions, the formal educational program, and one subsequent treatment session. As in the earlier pilot study, initial engagement and educational sessions with families were followed by biweekly single-family clinician sessions or multiple-family group sessions aimed at problem solving for the 2 years of the study. The multiple-family group aimed to extend the social network of the patient and the family and to reduce the isolation and stigma caused by mental illness.

Ashraf Mohamed Ali El-Tantawy1, Yasser Mohamed Ray (1899), conducted a randomized controlled trial study on Effectiveness of Psychoeducation and Mutual Support Group Program for Family Caregiver of Chinese People with Schizophrenia among sample of 68 Chinese families of schizophrenia sufferers in Hong Kong, who were randomly assigned to either a family psychoeducation and support group (n = 34), or a routine care group (n = 34). The interventions were delivered at two psychiatric outpatient clinics over a nine-month period. Results of multivariate analyses of variance test indicated that the family psycho educational intervention and support group reported greater improvements on family and patient functioning [F (2, 95) = 4.68, p < .01]and shorter lengths of patient hospitalizations at the two post-tests (one month and one year after completion of the intervention), compared with the routine care group. The findings substantiate that within a Chinese context, family psycho educational intervention and mutual support group intervention can effectively help families care for a mentally ill relative.

Mao-Sheng Ran · Meng-Ze Xiang · Cecilia Lai-Wan Chan · Julian Leff · Peggy Simpson · Ming-Sheng Huang · You-He Shan · Si-Gan Li (1985) Effectiveness of family psycho educational intervention for rural Chinese families experiencing schizophrenia A randomized controlled trial The aim of this study was to explore the characteristics and efficacy of psychoeducational family intervention for persons with schizophrenia in rural China. A cluster randomizxed controlled trial of psychoeducational family intervention for families experiencing schizophrenia (three groups, 326 cases) was conducted in Xinjin County,Chengdu. Treatment groups consisted of family intervention and medication, medication alone, and a control. The results showed a gain in knowledge, a change in the relatives 'caring attitudes towards the patients, and an increase in treatment compliance in the family

psycho educational intervention al family intervention group (p<0.05, 0.001).Most importantly, the relapse rate over 9 months in this group (16.3 %) was half that of the drug-only group (37.8 %), and just over one-quarter of that of the control group (61.5 %) (p<0.05). Antipsychotic drug treatment and families 'attitudes towards patients after the 9-month follow- up were significantly associated with clinical outcome (p<0.05).

LITERATURE RELATED TO THE EFFECT OF FAMILY PSYCHO EDUCATIONAL INTERVENTION ON CAREGIVER BURDEN AMONG THE PRIMARY CAREGIVER OF SCHIZOPHRENIA CLIENTS

Farkhondeh Sharif, **Maryam Shaygan** and **Arash Man (2012),** conducted a randomized controlled trial study on effectiveness of family psycho-education in reducing patients' symptoms and on family caregiver burden. Seventy Iranian outpatients with a diagnosis of schizophrenia disorder and their caregiver were randomly allocated to the experimental (n = 35) or control groups (n = 35). Patients in the experimental group received antipsychotic drug treatment and a psycho-educational program was arranged for their caregiver. The psycho-educational program consisted of ten 90-min sessions held during five weeks (two session in each week). Each caregiver attended 10 sessions (in five weeks) At baseline, immediately after intervention, and one month later. Validated tools were used to assess patients' clinical status and caregiver burden. Compared with the control group, the case group showed significantly reduced symptom severity and caregiver burden both immediately after intervention and one month later. The mean scores at time 0 (baseline) and time 2 (one month post-intervention) indicated that the experimental group had improved steadily in the global BPRS score (P < 0.037) and family burden

($P < 0.0001$). . The results suggest that even a short-term psycho-educational intervention for family members of patients with schizophrenia can improve the outcomes for patients and their families. In addition, our results showed a correlation between symptoms of schizophrenia and family burden.

Hogarty (2002), conducted a randomized controlled trial study on the effect of psycho-educative family therapy on the self-assessed burden in families in which one member has suffered from relapse of schizophrenia or a schizoaffective syndrome, 31 families in which one family member suffered from schizophrenia or a schizoaffective syndrome. Of these, 14 families underwent a psycho-educative intervention programme called BFT (Behavioural Family Therapy). The remaining 17 families, i. e. the contrast group, received conventional family support. The intervention was initiated within 24 h after the patient/family member was admitted to a psychiatric ward due to relapse of the psychotic disorder. The intervention continued until the patient was discharged from hospital. Falloon's Distress Scale and Attitude Scale were used in the families' self-assessments of burden and attitude towards continuing to take care of the patient, respectively. The self-assessments were performed on three occasions: 1) on the day of admission to the ward, or the day after; 2) 4–5 weeks after admission; and 3) on the day of discharge, or the day after. Medication doses were registered upon admission and at the time of discharge. The results suggest that BFT, when provided to schizophrenic patients and their families during a hospitalisation period caused by a psychotic relapse, reduces the feeling of burden in these families. Likewise, the families' attitude towards continuing to take care of the patients was influenced in a positive way.

Leff and colleagues (1990) randomly assigned 24 patients with schizophrenia who had lived with their relatives for at least 3 months before admission, had at least 35 hours per week of face-to-face contact with family members, and had high EE to a treatment-as-usual control group or a family intervention package. The family

intervention included a home-based psychoeducational program, a multifamily support group, and a home-based family therapy. At 9 months, 1 patient (8%) from the treatment group relapsed as opposed to 6 patients (50%) in the control group ($p < 0.05$).

2.2 CONCEPTUAL FRAME WORK

A framework is a brief explanation of theory or those portions of a theory which are to be tested in a quantitative study. A conceptual framework is one that presents logically constructed concepts to provide general explanation of relationship between the concepts of the research study; they are usually constructed by using researcher's own experiences, previous research findings, or concepts of several theories or models.

Conceptual framework facilitates communication and provides for a systemic approach to nursing research, education, administration and practice. The conceptual framework selected for this research study was based on Imogene M. King's "Transaction model"

The theory focus on interpersonal systems reflects King's belief that the practice of Nursing is differentiated from that of other health profession by what Nurses do with and for individual. The major elements of the theory are "in the interpersonal systems in which two people, who are usually strangers, come together in a health care organization to help and be helped to maintain a state of health that permits functioning in roles.

The concepts of the theory are perception, action, interaction and transaction. These concepts are interrelated in every Nursing situation. These terms are defined as concepts in the conceptual framework.

Perception: Perception is each person's representation of reality the elements of perception are importing of energy from the environment and organizing it by

information, transforming energy, processing information storing information and exporting information in the form of overt behaviors.

In this study, investigator perceives that there is lack of knowledge and proper attitude regarding care of schizophrenia among primary caregiver of schizophrenia clients. Primary caregiver have a varied perception towards schizophrenia and have excessive burden to give care to them

Action: Action refers to the activity to achieve the goal what the individual perceives. In this study, it is a mutual goal setting to reduce primary care giver burden. Investigator prepares family psycho educational intervention and caregiver burden scale to assess the caregiver burden.

Interaction: Interaction refers to the perception and communication between a person and the environment or between two or more persons. In this study the investigator administers family psycho educational intervention primary caregiver of schizophrenia clients for 45 minutes.

Transaction: Transaction is a process of interaction in which human beings communicate with the environment to achieve the goals that are evaluated and directs human behavior. In this study there is a gain in knowledge and attitude regarding schizophrenia and lowering the caregiver burden of primary caregiver of schizophrenia clients.

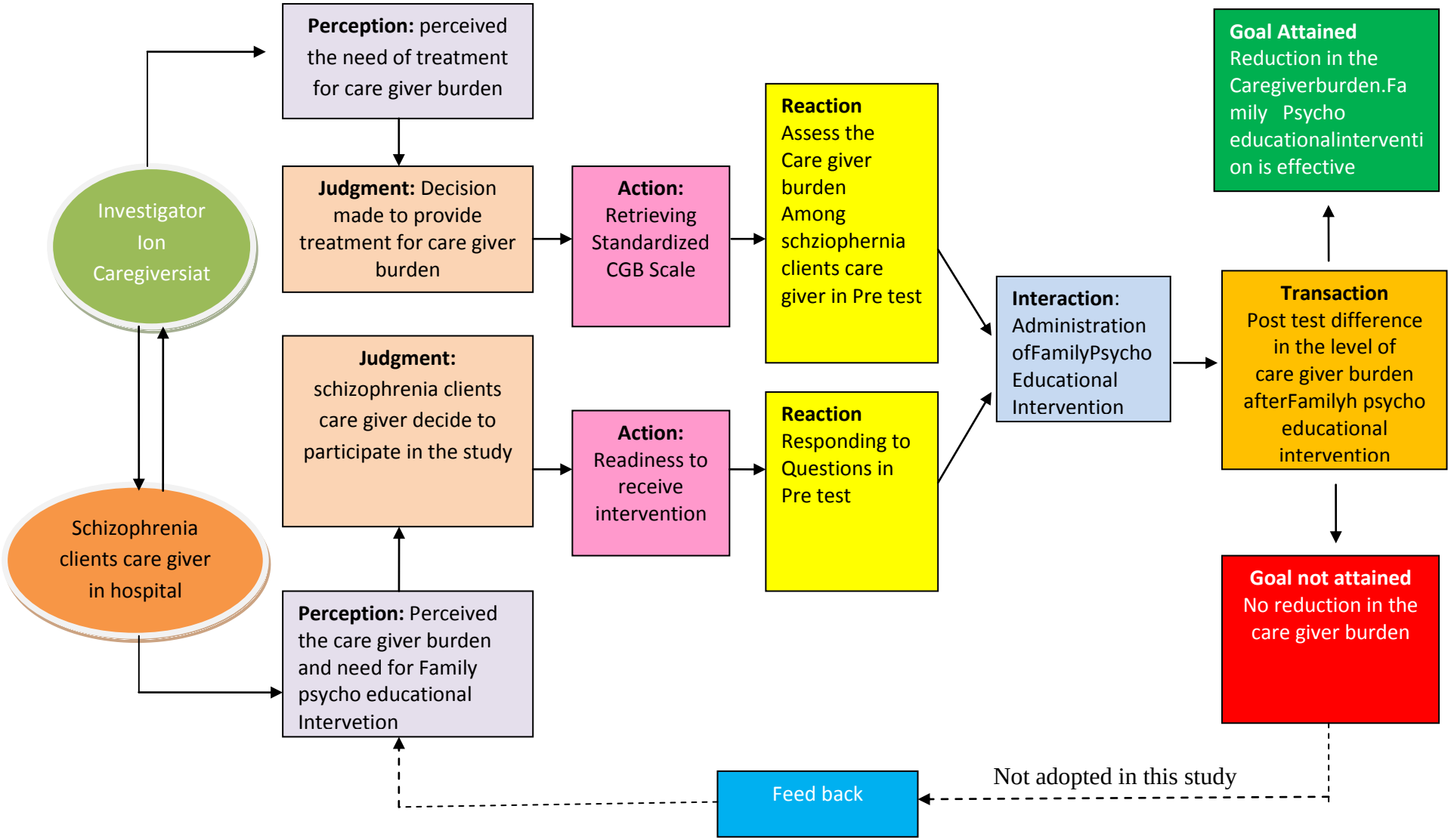

Fig.1. Theoretical Frame Work Based on modified King's Goal Attainment Theory

CHAPTER- III

RESEARCH METHODOLOGY

Research methodology is the overall plan for addressing the research problem and it covers multiple aspects of study's structure. It acts as a guide for planning, implementation and analysis of the study. It includes the descriptions of the research approaches, research design dependent and independent variables, sampling design, description of the tool, pilot study, and a planned format for data collection and a plan for data analysis.

3.1RESEARCH APPROACH

The research approach used for this study is quantitative approach. This study consists of pre test, family psycho educational intervention and post test method**.**

3.2 RESEARCH DESIGN

The research design selected for this study is Pre experimental (one group pre test- post test)design.

GROUP	PRE TEST O1	INTERVENTION X	POST TEST O2
Pre experimental Group	Post test to assess the caregiver burden among primary caregiver of schizophrenia clients by caregiver burden scale .	Family psycho educational intervention was given 45minutes, daily for 6 consecutive days.	Post test to determine the level of caregiver burden of primary caregiver of schizophrenia client by using the same tool.

3.3.RESEARCH VARIABLES

Variables are characteristics that vary among the family psycho educational intervention being intervention.

Independent variable:

Family psycho educational intervention

Dependent variable:

Caregiver burden among primary caregiver of schizophrenia clients

Demographic Variable:

Age, education, place of domicile, occupation, income, marital status, Religion, Number of children, Type of family, Duration of suffering schizophrenia..

3.4 SETTING OF THE STUDY

The study was conducted in Government Rajaji Hospital, Psychiatry Ward,Madurai.20. This setting is within the same campus to college of nursing This setting was selected based on acquaintance of the investigator with the institution, feasibility of conducting the study, availability of the sample, permission and proximity of the setting to investigation.

3.5 POPULATION

The population of the study was primary caregiver of schizophrenia clients.

TARGET POPULATION

Target population is primary caregiver of schizophrenia clients

ACCESSIBLE POPULATION

The Accessible population comprised of Primary caregiver of schizophrenia clients who were admitted in Government Rajaji Hospital at Madurai.

3.6 SAMPLE

The sample of this was primary caregiver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai and those who fulfilled the inclusion criteria

3.7 SAMPLE SIZE

The sample size of the study was 60 primary caregiver of schizophrenia client admitted in Government Rajaji Hospital at Madurai.

3.8 SAMPLING TECHNIQUE:

60 primary caregiver of schizophrenia clients were selected by Purposive sampling technique.

3.9 CRITERIA FOR SAMPLE SELECTION

INCLUSION CRITERIA

- Male and Female primary caregiver of schizophrenia clients, admitted in Government-Rajaji Hospital, Madurai.
- Primary caregiver those who understand either Tamil or English.
- Primary caregiver who were available at the time of data collection.

EXCLUSION CRITERIA

- Primary care giver of schizophrenia clients those who were not willing to participate in the study.
- Primary care giver of schizophrenia clients who were ready for discharge of the day of data collection.
- Primary caregiver of schizophrenia clients who were not co-operative.

3.10 DEVELOPMENT AND DESCRIPTION OF TOOL

After extensive review of literature and discussion with the experts and with the researcher's personal and professional experience caregiver burden scale was used to assess the caregiver burden

The tool for data collection consists of 2 parts.

PART - I

Section A- Consisted of Socio demographic variables such as Age ,Education, Place of domicile, Occupation, Income, Marital Status, Religion, Number of children, Type of family, Duration of suffering illness .

Section B- Care Giver Burden Scale

3.11 SCORING PROCEDURE AND SCORING KEY

Section A: Caregiver burden scale (CG'BS by R.THARA 1995 WHO)

Section B: Caregiver burden scale (CG'BS) – a 20 item questionnaire rated on a 3 point scale:

- Scores were calculated as followed negative items;1,3,4,5,13,16,19 (3) not at all ,(2)to some extent (1)very much are scored in reverse in valent.
- The positive items ;2,6,7,8,9,10,11,12,14,15,17,18,20 (1)not at all (2)to some extent(3)very much are scored in reverse in valent.

SCORING:

Level of scoring	Interposttation
HIGHER IN VALUE	40<60
LOWER IN VALUE	20<41

3.12 VALIDITY AND RELIABILITY OF THE TOOL

In order to measure, the content was validated by 5 experts in the field of psychiatry, psychology and psychiatric nursing; Based on the validity suggestion the test was finalized. This same test was used for the pilot study in this same to assess the study. The result of the pilot study evidenced that, there was a significant increase the level of caregiver burden after the family psycho educational intervention .

The reliability of the tool for caregiver burden questionnaire was assessed by test – retest method. The reliability score was r= 0.88 hence the tool was reliable and was used in the study.

3.13 PILOT STUDY

The pilot study was conducted at Psychiatric ward Government Rajaji Hospital Madurai.

Pilot study was conducted in the month of August (01.08.2013 to 07.08.13) for a period of one week. The researcher selected 10 subjects using (non- probability) purposive sampling method, who fulfilled the inclusion criteria as samples. Verbal and written consent was obtained from the subjects for taking part in the study. The posttest was given to the samples on the day '1' The post test was conducted on the day '6'.

Findings of the pilot study revealed that the study was feasible and practicable to conduct the main study in Psychiatric ward Government Rajaji Hospital Madurai. The data collection for the main study was planned to be done by excluding the samples in the pilot study. It revealed that there was a significant difference between the post test and post test scores on caregiver burden among primary caregiver of

schizophrenia clients. The caregiver burden level is lower after the family psycho educational intervention .

3.14 PROCEDURE FOR DATA COLLECTION

Prior to data collection necessary permission was obtained from the ethical committee, HOD of psychiatry Department, Government Rajaji Hospital,Madurai.20. The data collection period was for 6 weeks from 01.9.2013 to 15.10.2013. The investigator divided the 60 caregiver in to four groups among each group have 15 caregiver .Following the assessment, one week of family psycho educational intervention was administered for each group All the subjects were makes attend the family psycho educational intervention disease, treatment and drug compliance, Reducing relapses, Re-hospitalization, communication and problem solving skills, effective way to express emotion, Family psycho educational intervention was given Every day for 45minutes for six consecutive days by group discussion. After 6^{th} day the whole content was summarized then post test was conducted on 6^{th} Day to assess the caregiver burden using the same scale..

Day1 –Introduction was given about the study for understand the **schizophrenia, symptoms, cause** session was given with video clips for 45minutes.

Day2 - Review the previous day topic content for 5 minutes. Issuing next content **medication, side effect and signs of relapse and relapse prevention** was conducted with flash cards for 45 minutes.

Day3 - Review the previous day topic content for 5 minutes. Issuing next content were **COMMUNICATION** was explained with Booklet for 45minutes.

Day4 – Review the previous day topic content for 5 minutes. Issuing next topic content **PROBLEM SOLVING SKILLS** was explained with Booklet for 45minutes

Day5 - Review previous day topic content for 5 minutes. Issuing next topic content **EFFECTIVE EXPRESSED EMOTION** session was given with video clips for 45minutes.

Day6 - Review previous day topic content for 5 minutes. Issuing next topic content

RELAXATION TECHNIQUE session was given with flashcards and teaching. for 45minutes.

Overall topic content discussed for other 45 minutes and post test were conducted.

1. I session - Disease condition, signs and symptoms, causes
2. II session - Treatment, side effect and signs of relapse, relapse Prevention.
3. III session - Communication
4. IV session - Problem solving skills
5. V session - Effective expressed emotion
6. VI session - Relaxation technique after 6 day the whole content was Summarised and Post Evaluation conducted.

PARTICIPATING STUDENTS IN EACH GROUP PER WEEK

INTRODUCTION - 5MINS ISSUING CONTENT - **DISEASE CONDITION,SIGNS AND SYMPTOMS,CAUSES**	DAY-I
REVIEW - 5MINS ISSUING CONTENT - **TREATMENT,SIDE EFFECT**	DAY-2
REVIEW - 5MINS ISSUING CONTENT - **COMMUNICATION**	DAY-3
REVIEW - 5MINS ISSUING CONTENT - **PROBLEM SOLVING SKILLS**	DAY-4
REVIEW - 5MINS ISSUING CONTENT - **EFFECTIVE EXPRESSED EMOTION**	DAY-5
REVIEW - 5MINS ISSUING CONTENT - **RELAXATION TECHNIQUES AFTER 6 DAY THE WHOLE CONTENT WAS SUMMARISED AND POST EVALUATION TEST CONDUCTED.**	DAY-6

3.15 PLAN FOR DATA ANALYSIS:

Data analysis is the process of organizing and synthesizing the data so as to answer research questions and test hypothesis. Data collection is followed by analysis and interpretation of data where the collected data are analyzed and interpreted in accordance with the study objectives. It involved the use of statistical procedures to give an organization and meaning to the data. Descriptive and inferential statistics used for data analysis. To compute the data, a master sheet was prepared by the investigator.

Descriptive statistics

1. Frequency and percentage distribution was used to analyze the Baseline variable
2. Mean and standard deviation was used to analyze the pretest and post test

caregiver burden among primary caregiver of schizophrenia clients

Inferential statistics

1. Paired t' test was used to compare pretest and post test level of caregiver burden
2. Chi-square analysis used to find out the association of post test level of caregiver burden with selected Baseline variables

3.16 PROTECTION OF HUMAN RIGHTS

The investigator obtained approval from dissertation committee, The Government Rajaji hospital ethical committee, and formal written permission from the HOD of Psychiatric ward Government Rajaji Hospital Madurai.. Each individual

client was informed about the purpose of the study and confidentiality was promised and ensured. Both verbal and written consent was obtained from all the study subjects and data collected was kept confidential. The names of the subjects were not disclosed in any form. The client had freedom to leave the study at their will without assigning any reason. Anonymity was maintained throughout the study.

3.17 SCHEMATIC REPRESENTATION OF THE RESEARCH METHODOLOGY

CHAPTER – IV

DATA ANALYSIS & INTERPRETATION

Analysis and interpretation of data is the most important phase of the research process, which involves the computation of certain measures along with searching for patterns of relationship that exists among data groups (Suresh K Sharma 2011). This chapter deals with analysis and interpretation of data collected from 60 primary caregiver of schizophrenic clients at Government Rajaji Hospital Madurai.

ORGANIZATION OF DATA

The findings of the study were grouped and analyzed under the following sections:

SECTION -I

Distribution on socio demographic variables of primary caregiver of schizophrenic clients

SECTION-II

Effectiveness of family psycho educational intervention regarding caregiver burden among primary caregiver of schizophrenia clients

SECTION-III

Association between post test caregiver burden level with selected socio demographical variables

SECTION –I

TABLE-1

Distribution of socio demographic variables of primary caregiver of schizophrenia clients

(n=60)

SOCIO DEMOGRAPHIC VARIABLE		FREQUENCY (f)	PERCENTAGE (%)
AGE	20-30 years	1	1.67
	31-40 years	0	0
	41- 50 years	48	80
	51-60 years	11	18.33
	61yrs and above	0	0
EDUCATION	Non Formal education	32	53.33
	Primary	28	46.67
	High School	0	0
	Higher Secondary	0	0
	Degree	0	0
PLACE OF DOMICILE	Urban	60	100
	Rural	0	0

SOCIO DEMOGRAPHIC VARIABLE		FREQUENCY (f)	PERCENTAGE (%)
	Sub Urban	0	0
OCCUPATION	Labor	59	98.33
	Government	1	1.67
	Private	0	0
	Self Employment	0	0
TOTAL INCOME OF FAMILY	< 2000	38	63.33
	2001-5000	22	36.67
	5001-10000	0	0
	> 10000	0	0
MARITAL STATUS	Unmarried	1	1.67
	Married	57	95
	Divorced	2	3.33
	Separated	0	0
RELIGION	Hindu	60	100
	Christian	0	0

SOCIO DEMOGRAPHIC VARIABLE		FREQUENCY (f)	PERCENTAGE (%)
	Muslim	0	0
NO.OF CHILDREN	No Issue	7	11.67
	One Child	16	26.67
	Two Children	27	45.0
	> Three children	10	16.7
TYPE OF FAMILY	Nuclear Family	41	68.33
	Joint Family	14	23.33
	Extended Family	5	8.33
DURATION OF ILLNESS	< 1 Year	20	33.33
	1-3 Years	13	21.67
	3- 5 Years	18	30.00
	> 5 Years	09	15.00

Table-1reveals that Majority of the subjects 48 (80%) of the care givers of schizophrenia were in the 41-50 years age group and 11(18.33%) of the care givers of schizophrenia were in the 51-60 years age group and 1(1.67%) of the care givers of schizophrenia were in the 20-30 years age group. None of them were 60 years and above.

- Majority of the participants 32 (53.33 %) had no formal education and 28 (46.67%) had studied up to family primary educational intervention none of them were higher secondary or graduate and above .
- All 60 (100 %) participants hailed from urban area none of them from rural or semi urban.
- Majority of the subjects 59 (98.33%) were labor and 1 (1.67%) were working in Government organizations.
- Majority of the subject's 38 (63.33%) monthly income were less than Rs.2000 and 22 (36.67 %) were earning up to Rs2001-5000 per month.
- Majority of the subjects 57 (95%) of subjects were married, 1 (1.67%) were unmarried and 2 (3.33%) were divorced.
- All participants (100 %) were Hindus. None of them were Muslim or Christian religion.
- Majority of subjects 27 (45%) had two children, 16 (26.67%) of subjects had one child, 10 (16.7%) had more than three children and 7 (11.67%) had no issue.
- Among the care givers of schizophrenia majority of them 41 (68.33%) living in nuclear family while 14 (23.33%) living in joint family and 5 (8.33%) living in extended family.
- This table shows that 20 (33.3%) duration of illness for less than 1 year period, 13 (21.67%) for l-3 years,18 (30%) for 3-5 years of period and 9 (15%) for more than 5 years.

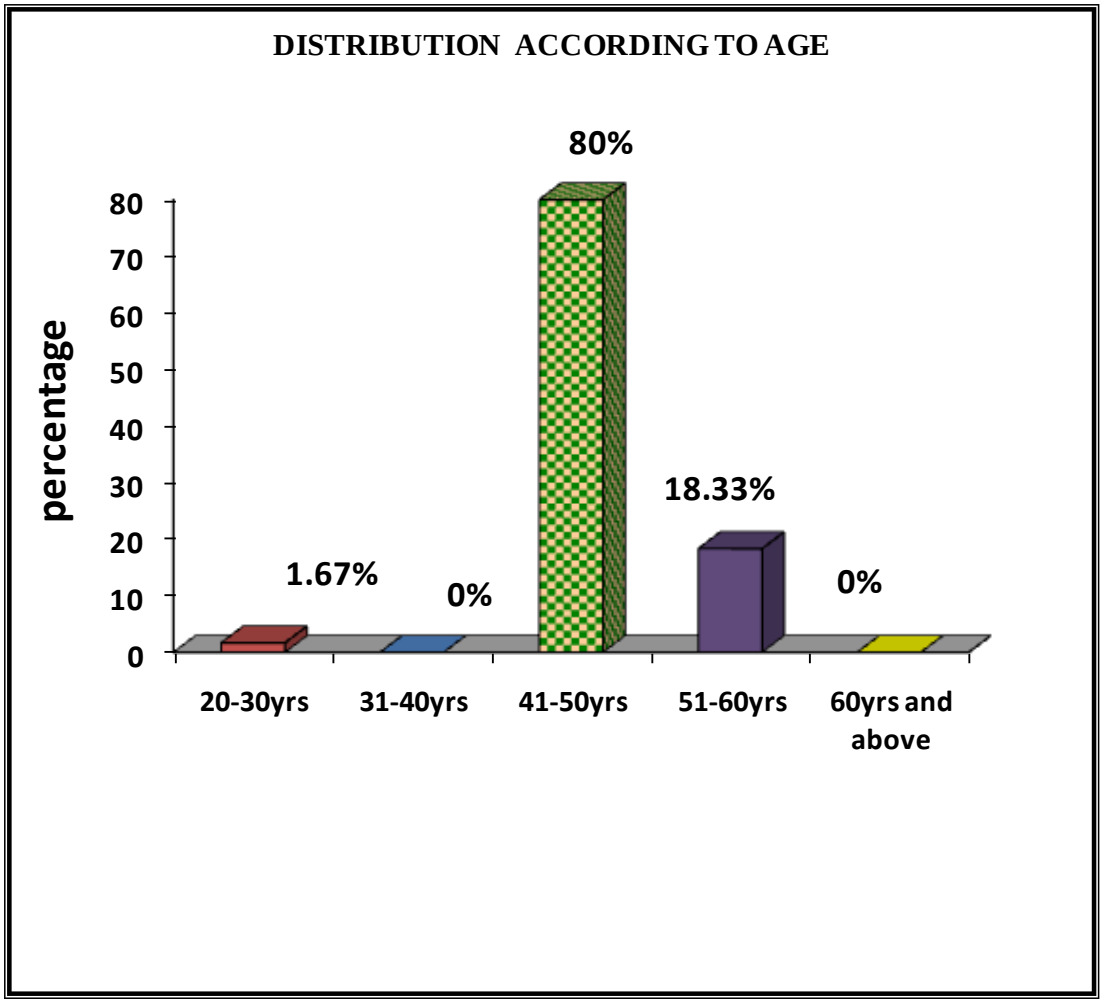

Figure- 3: A Bar diagram showing distribution of primary caregiver of clients with schizophrenia according to their age.

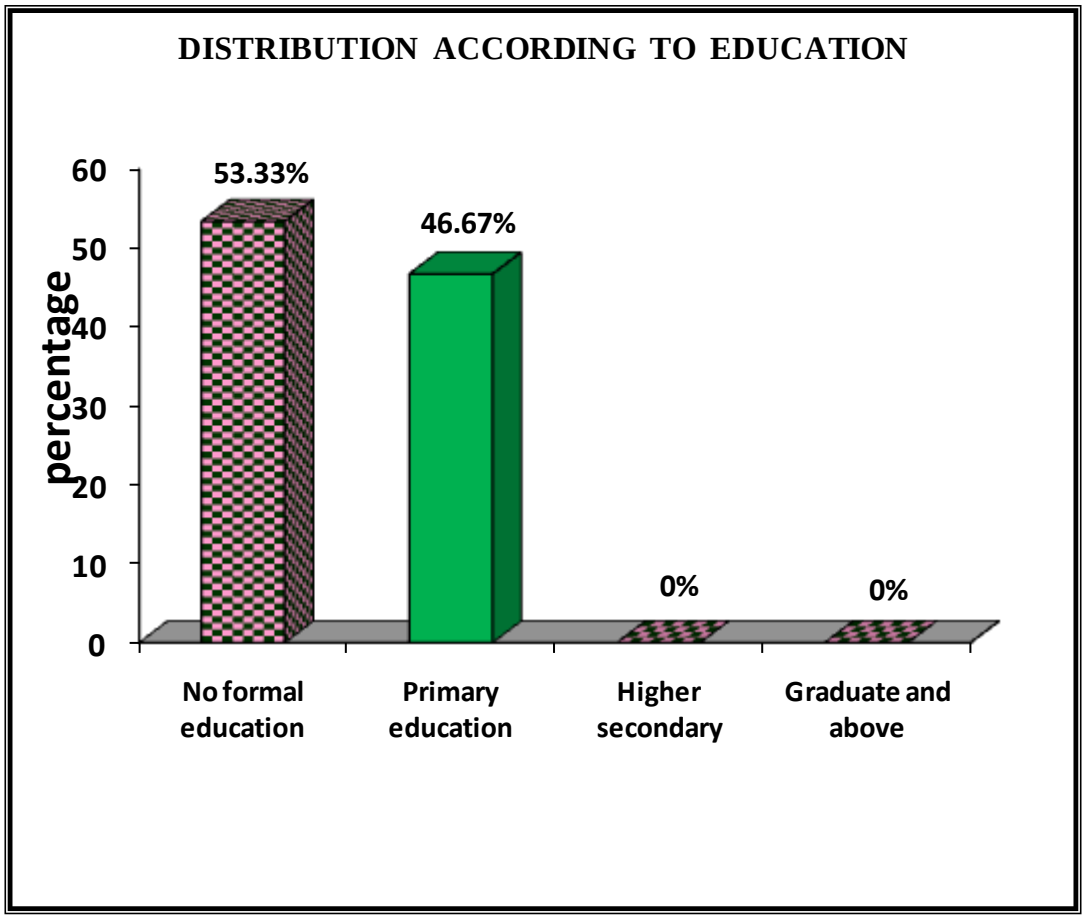

Figure- 4: A Bar diagram showing distribution of primary caregiver of clients with schizophrenia according to their education.

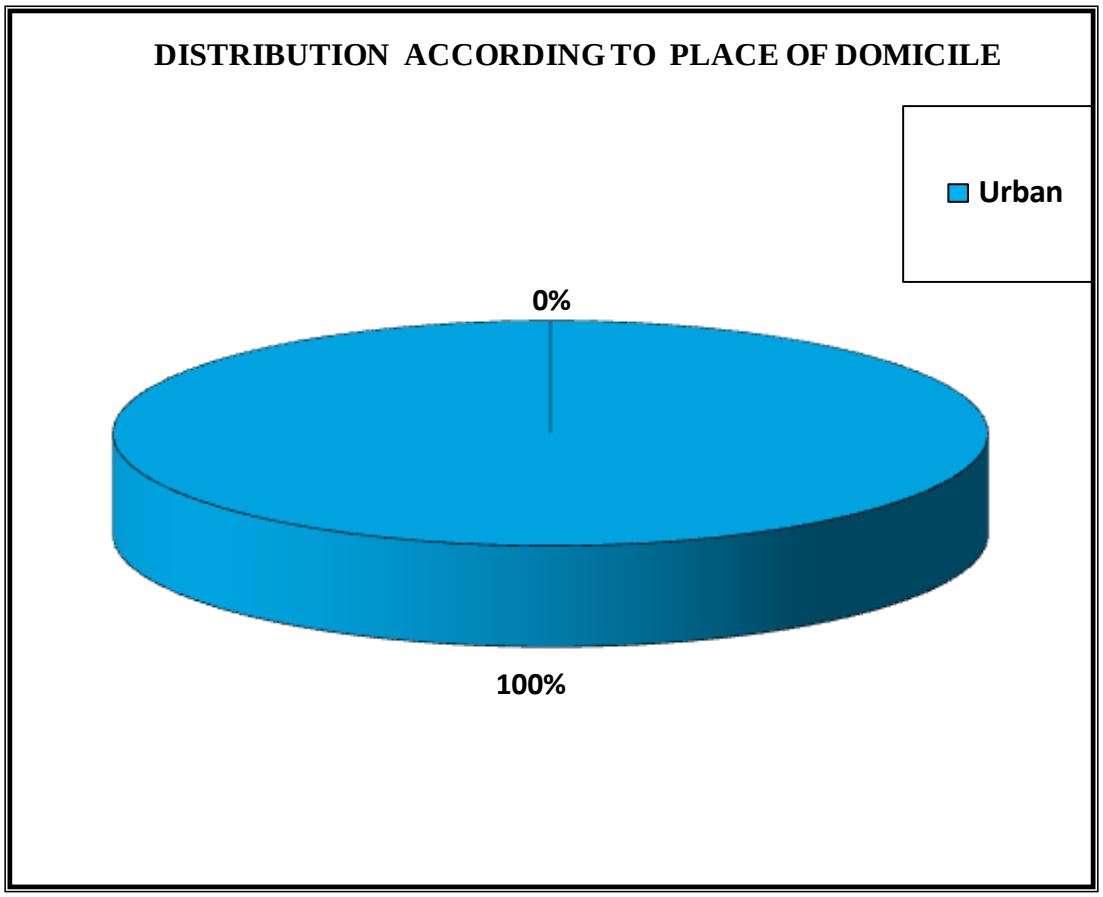

Figure- 5: A Pie chart showing distribution of primary caregiver of clients with schizophrenia according to their place of domicile.

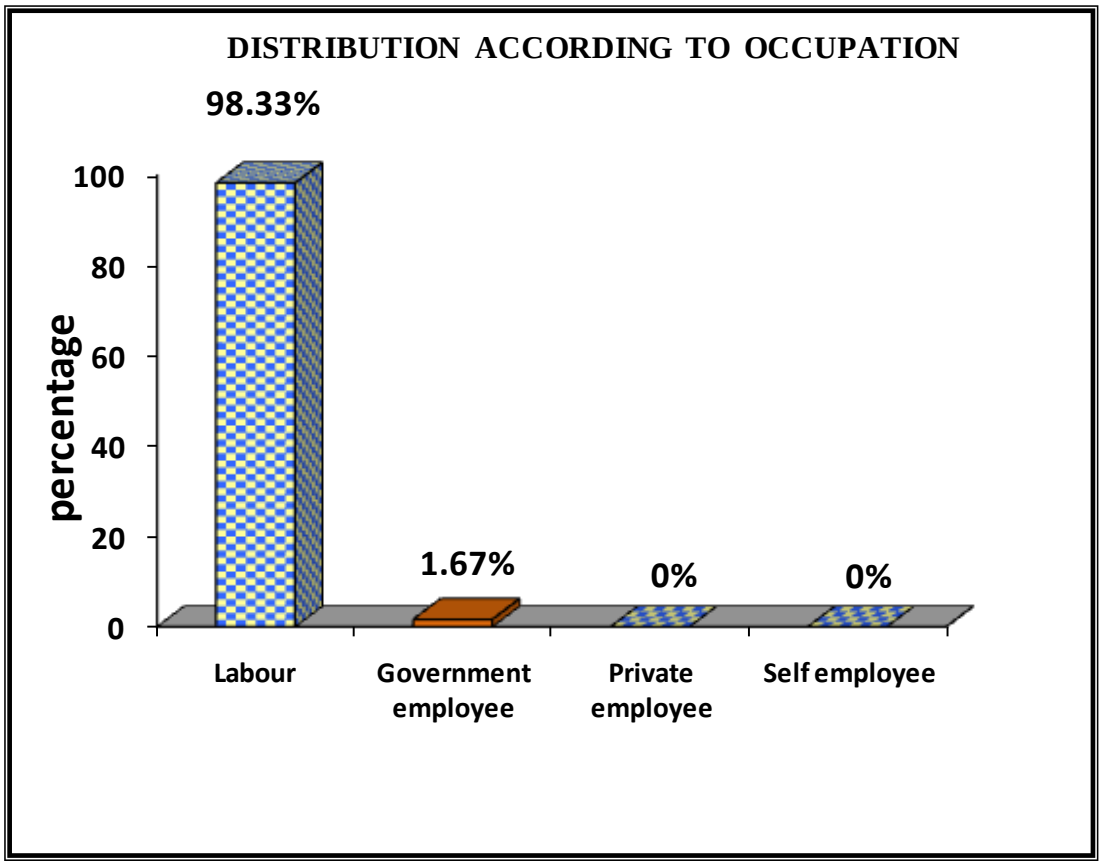

Figure- 6: A Bar diagram showing distribution of primary caregiver of clients with schizophrenia according to their occupation.

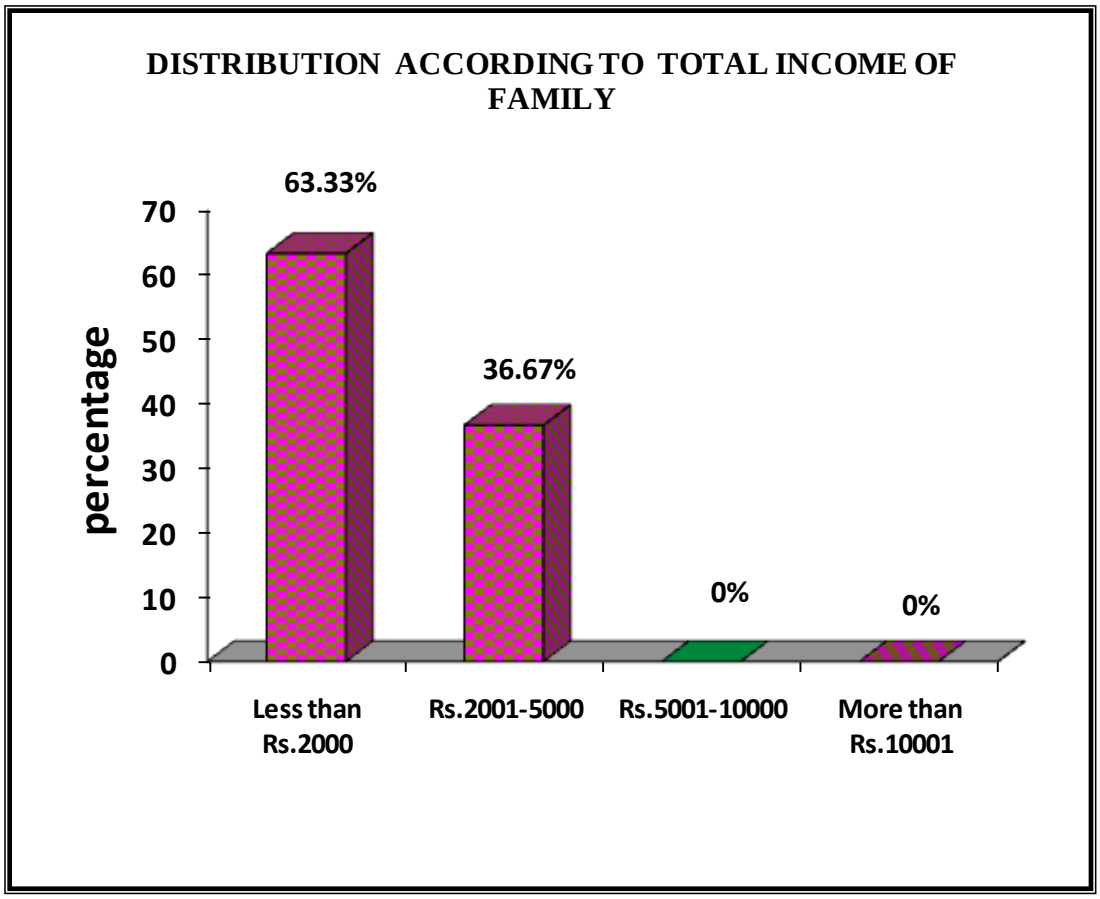

Figure- 7: A Bar diagram showing distribution of primary caregiver of clients with schizophrenia according to their total income of family.

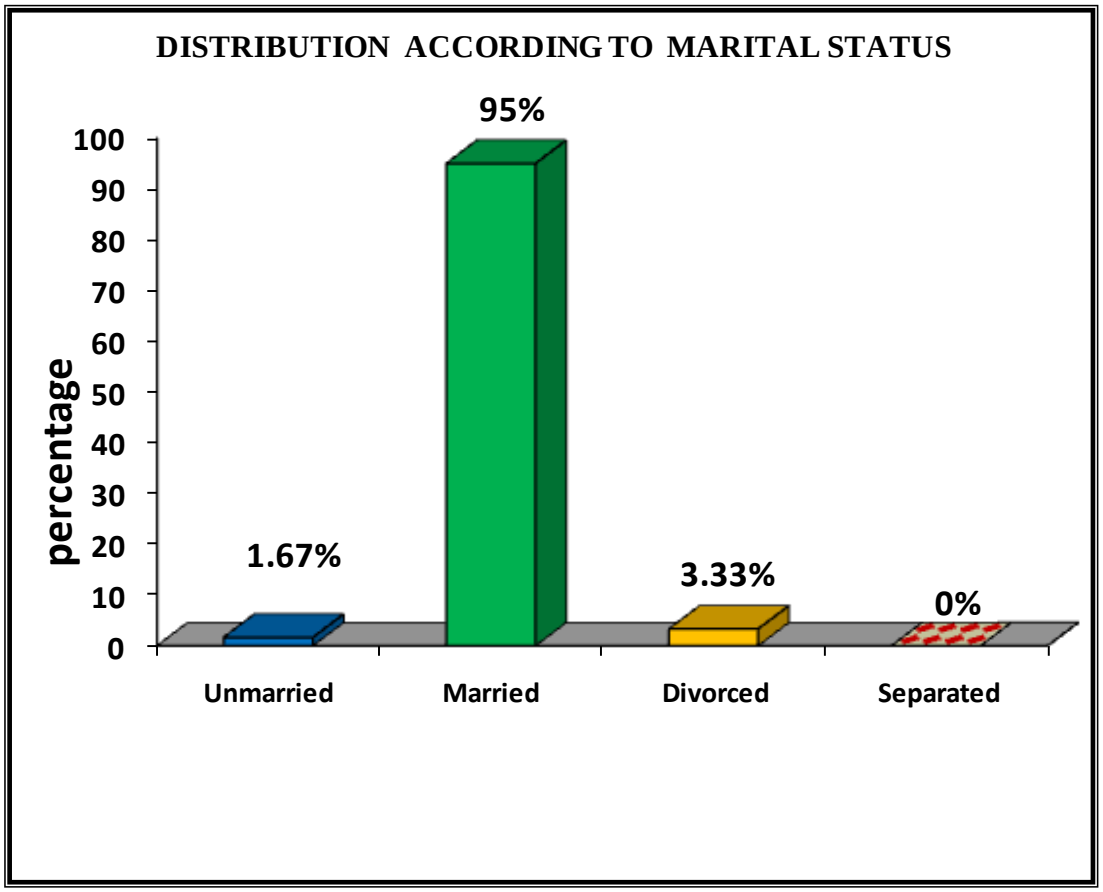

Figure- 8: A Bar diagram showing distribution of primary caregiver of clients with schizophrenia according to their marital status.

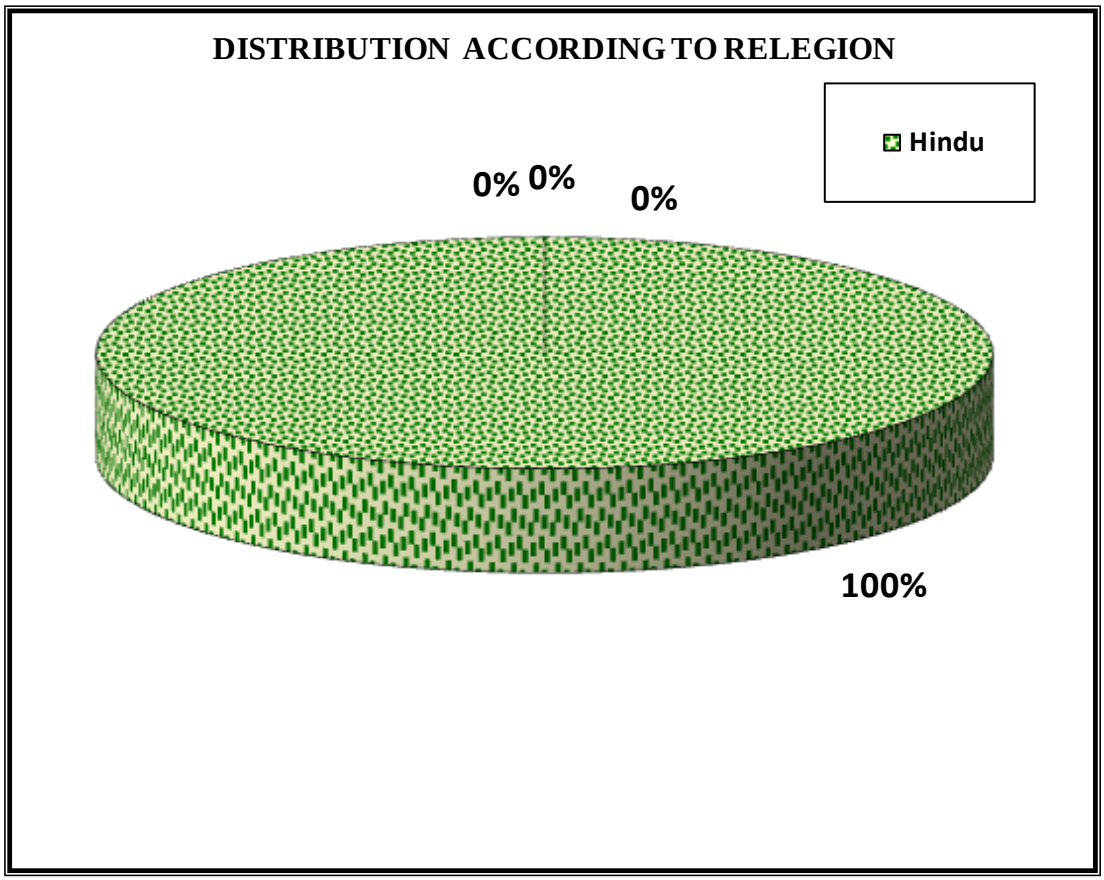

Figure- 9: A Pie chart showing distribution of primary caregiver of clients with schizophrenia according to their religion.

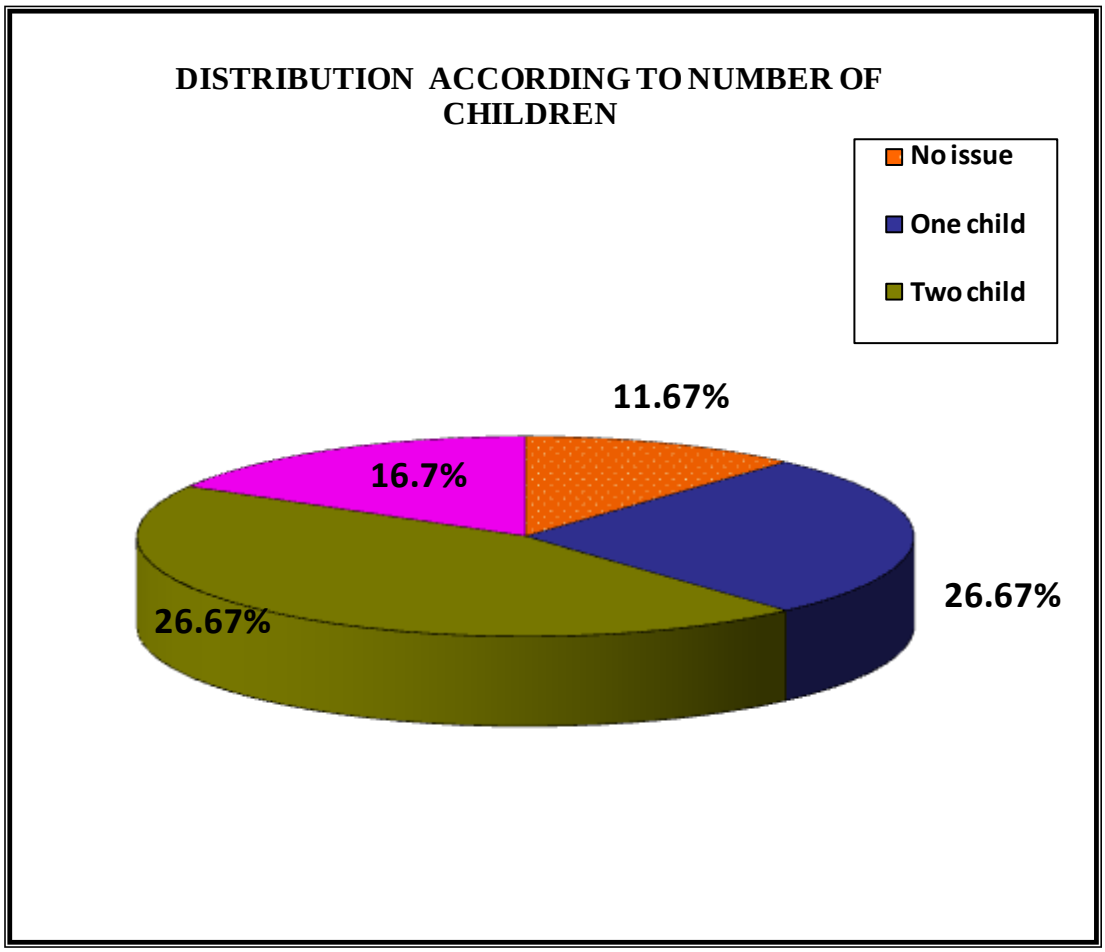

Figure- 10: A Pie chart showing distribution of primary caregiver of clients with schizophrenia according to their number of children.

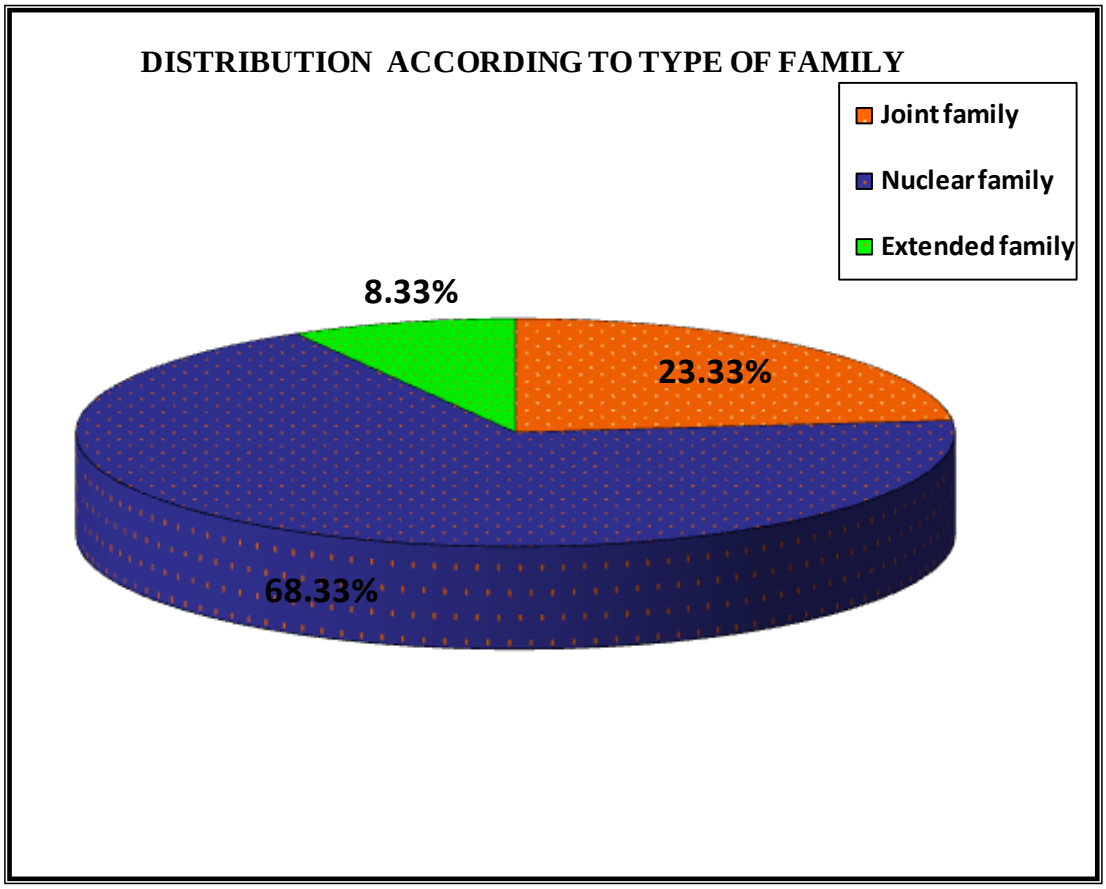

Figure- 11: A Pie chart showing distribution of primary caregiver of clients with schizophrenia according to their type of family.

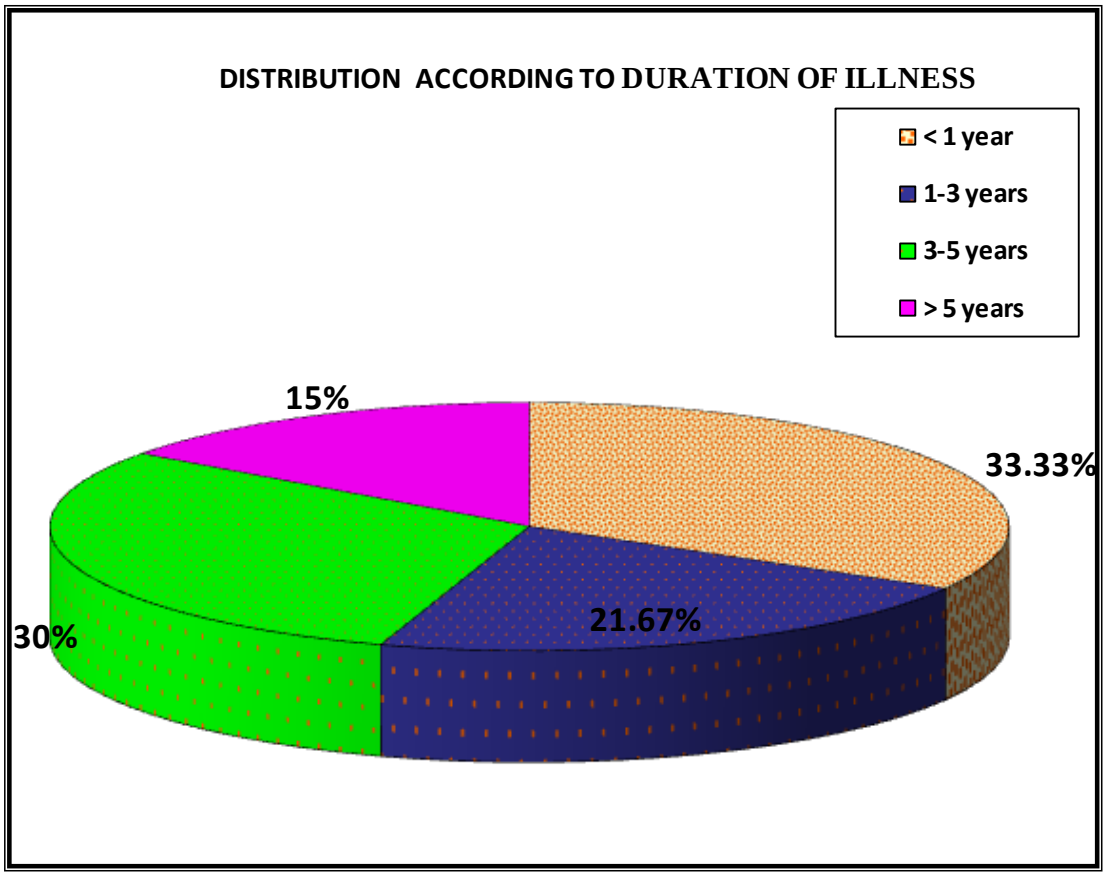

Figure- 12: A Pie chart showing distribution of primary caregiver of clients with schizophrenia according to their type of family.

SECTION II

TABLE : 2

DISTRIBUTION OF SUBJECTS

ACCORDING TO THEIR CAREGIVER BURDEN LEVEL.

Level of caregiver burden	Pre test		Post test	
	Frequency (f)	Percentage (%)	Frequency (f)	Percentage (%)
Low caregiver burden level	16	26.67	36	60
High caregiver burden level	44	73.33	24	40
Total	60	100	60	100

In the pretest The data collection period was for 6 weeks from 01.9.2013 to 15.10.2013. The investigator divided the 60 caregiver in to four groups among each group have 15 caregiver .Following the assessment, one week of family psycho educational intervention was administered for each group All the subjects were makes attend the family psycho educational intervention disease, treatment and drug compliance, Reducing relapses, Re-hospitalization, communication and problem solving skills, effective way to express emotion, Family psycho educational intervention was given Every day for 45minutes for six consecutive days by group

discussion. After 6th day the whole content was summarized then post test was conducted on 6th Day to assess the caregiver burden using the same scale..

Where as in the post test after family psycho educational intervention majority of primary caregiver 60% of primary caregiver had low level care givers burden, and the remaining 40% participant had high level of caregiver burden.

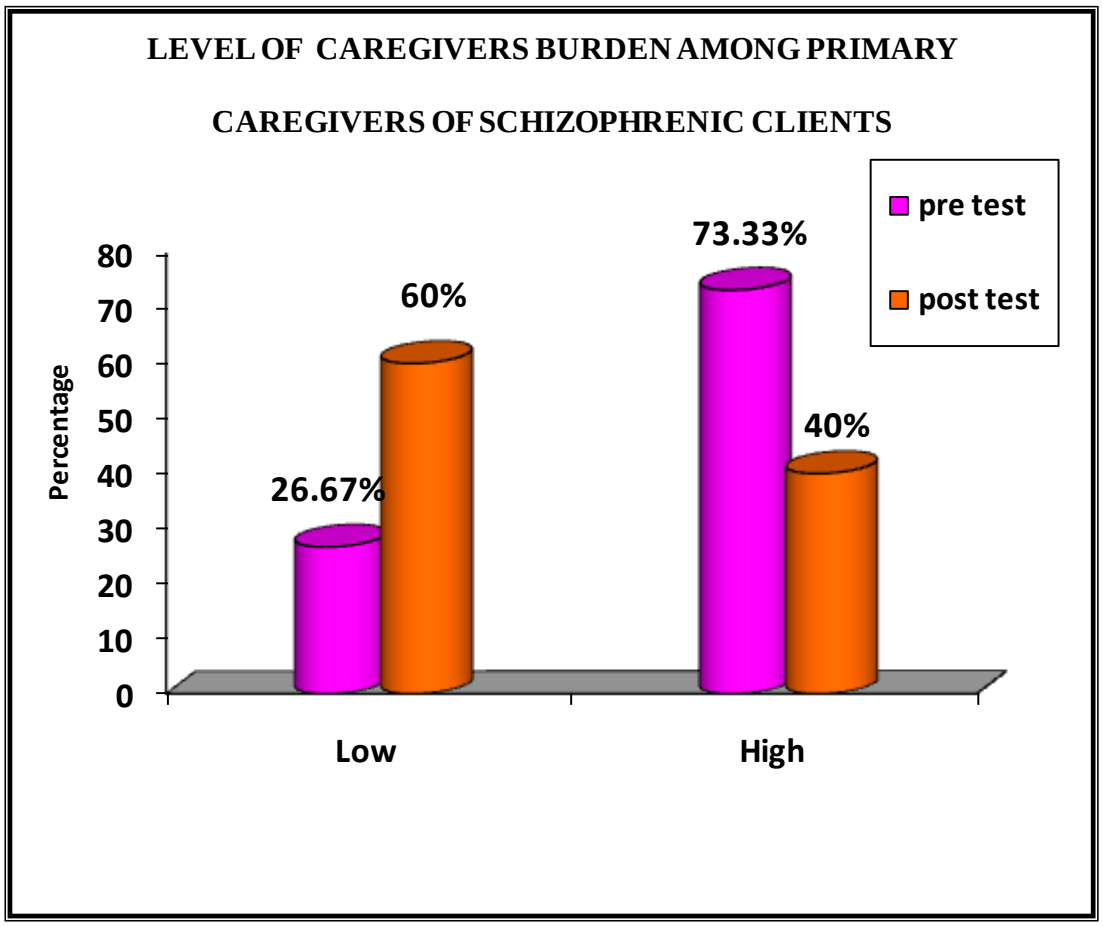

Figure- 12: A Cylinder diagram showing distribution of subjects according to their caregiver burden level.

SECTION – III

Table : 3

EFFECTIVENESS OF FAMILY PSYCHO EDUCATIONAL INTERVENTION ON CAREGIVER BURDEN AMONG PRIMARY CAREGIVER OF SCHIZOPHRENIA CLIENTS

Variable	Mean	Mean Difference	SD	"t"-Value	P-Value
Post-Test	43.48	6.37	8.49	13.11*	0.05
Post-Test	37.12		7.15	(2.000)	

*** - Significant at 0.05 level**

The above table showed that the Mean Pre test and Post test was 43.48 and 37.12 respectively and Standard Deviation was 8.49 and 7.15 respectively. The Mean difference was 6.37. The paired "t" test value was 13.11. The Calculated value was greater than the table value (2.000), there was a significant difference between the pre test and post test caregiver burden level, this difference might be due to the family psycho educational intervention also this difference was purely by chance and not by choice. Hence it was inferred that family psycho educational intervention was effective on caregiver burden levels among the primary caregiver of clients with schizophrenia.

EFFECTIVENESS OF FAMILY PSYCHO EDUCATIONAL INTERVENTION ON CAREGIVER BURDEN AMONG PRIMARY CAREGIVER OF SCHIZOPHRENIA CLIENTS

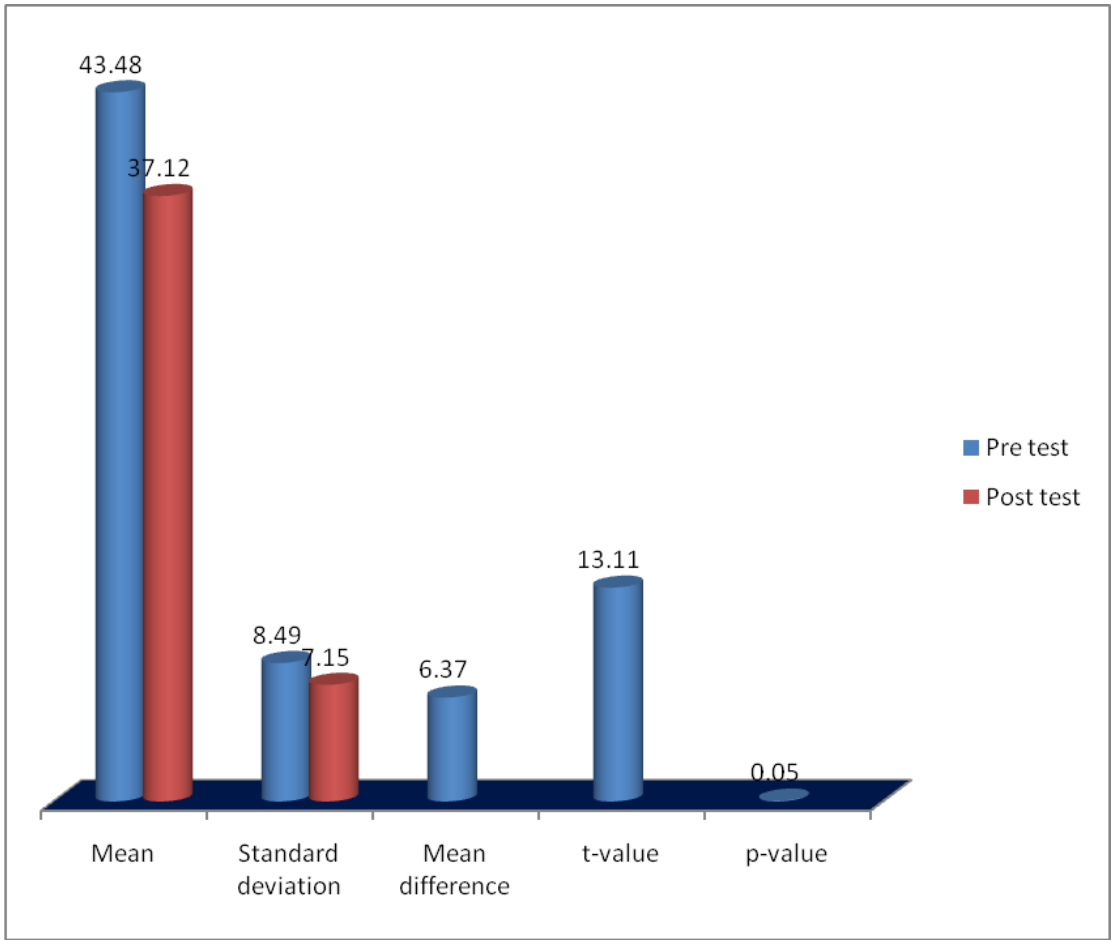

Figure. 14: A Cylinder diagram showing Effectiveness of Family psycho educational intervention on caregiver burden levels among the primary caregiver of clients with schizophrenia.

SECTION- IV

Table No: 4

ASSOCIATION BETWEEN POST TEST LEVEL OF CAREGIVER BURDEN LEVELS AMONG THE PRIMARY CAREGIVER OF CLIENTS WITH SCHIZOPHRENIA AND THEIR SELECTED SOCIO DEMOGRAPHIC VARIABLES

Socio demographic variables	High burden		Low burden		χ^2
	f	%	f	%	
Age (in years):					
20 yrs to 30 yrs	1	1.7	0	0	
31yrs to 40 yrs	-	-	0	0	3.16
41yrs to 50 yrs	13	21.7	35	58.3	
51yrs to 60 yrs	2	3.3	9	15	
60yrs and above	--	-	-	-	
Education :					
No formal education	11	18.3	21	35	
Primary education	5	8.3	23	38.3	9.84*
Higher secondary	-	-	-	-	
Graduate and above	-	-	-	-	
Place of domicile:					
Urban	16	26.7	44	73.3	0.074
Rural	-	-	-	-	
Sub urban	-	-	-	-	

Socio demographic variables	High burden		Low burden		$\chi 2$
	f	%	f	%	
Occupation:					
Private employee	16	26.7	43	71.7	
Government employee	0	0	1	1.7	8.214*
Labour	-	-	-	-	
Self employee	-	-	-	-	
Total income of family:					
Less than Rs.2000	10	16.7	28	46.7	
Rs.2001-5000	6	10	16	26.6	0.006
Rs.5001-10000	-	-	-	-	
More than Rs.10001	-	-	-	-	
Marital status:					
Unmarried	0	0	1	1.7	
Married	15	25	42	70	0.924
Divorced	1	1.7	1	1.7	
Separated	-	-	-	-	
Religion					
Hindu	16	26.7	44	73.3	
Christian	-	-	-	-	
Muslim	-	-	-	-	0.45
Others	-	-	-	-	

Socio demographic variables	High burden		Low burden		χ2
	f	%	f	%	
Number of children :					
No child	3	26.7	4	7.3	
One child	7	12.4	9	15.3	1.865
Two child	10	16.6	17	31.4	
Three and above	3	5.9	7	12.4	
Type of family :					
Nuclear family	10	16.7	31	51.7	0.589
Joint family	4	6.7	10	16.6	
Extended family	2	3.3	3	5	
Duration of illness :					
< 1 year	16	26.7	4	7.3	
1-3 years	-	-	13	21.7	2.345
3-5 years	5	8.3	13	21.7	
5 years	4	7.2	5	8.3	

*** - Significant at 0.05 level**

This table showed that Chi square (χ2**)** Value for different Socio demographic variables. The above table explained that number (f) of primary caregiver at different level of caregiver burden. Level of caregiver burden among primary caregiver in the post test was significantly associated with their education since the calculated value 9.84 was greater than table value 7.82 and also with their occupation since the calculated value 8.214 was greater than table value 7.82 at P<0.05. All other variables were not significantly associated among the primary caregiver with their post test score of caregiver burden.

CHAPTER-V

DISCUSSION

Based on the objectives of the study and hypotheses, this chapter deals with the detailed discussion of the results of the data inter posted from the statistical analysis. The purpose of the study was to evaluate the Effectiveness of family psycho educational intervention on caregiver burden among primary caregiver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai.

DISCUSSION OF DEMOGRAPHIC VARIABLES

- Majority of the subjects 48 (80%) of the were in the care givers of schizophrenia 41-50 years age group and 11(18.33%) were in the care givers of schizophrenia 51-60 years age group and 1(1.67%) of the care givers of schizophrenia were in the 20-30 years age group. None of them were 60 years and above.
- Majority of the participants 32 (53.33 %) had no formal education and 28 (46.67%) had studied up to primary education none of them were higher secondary or graduate and above .
- All 60 (100 %) participants hailed from urban area none of them from rural or semi urban.
- Majority of the subjects 59 (98.33%) were labor and 1 (1.67%) were working in Government organizations.
- Majority of the subject's 38 (63.33%) monthly income were less than Rs.2000 and 22 (36.67 %) were earning up to Rs2001-5000 per month.

- Majority of the subjects 57 (95%) of subjects were married, 1 (1.67%) were unmarried and 2 (3.33%) were divorced.
- All participants (100 %) were Hindus. None of them were Muslim or Christian religion.
- Majority of subjects 27 (45%) had two children, 16 (26.67%) of subjects had one child, 10 (16.7%) had more than three children and 7 (11.67%) had no issue.
- Among the care givers of schizophrenia majority of them 41 (68.33%) living in nuclear family while 14 (23.33%) living in joint family and 5 (8.33%) living in extended family.
- Majority of subjects 20 (33.3%) care giver of schizophrenia for less than 1 year period, 13 (21.67%) care giver of schizophrenia for l-3 years,18 (30%) care giver of schizophrenia for 3-5 years of period and 9 (15%) care givers of schizophrenia for more than 5 years.

DISCUSSION OF THE STUDY BASED ON ITS OBJECTIVES

The first objective of the study was to assess the pretest level of caregiver burden among primary caregiver schizophrenia clients.

Table 2 Depicts that in the pretest majority of then 73.33%had high level care giver burden. 26.67% of the primary caregiver had low level **c**are giver burden

The second objective was to evaluate the effectiveness of family psycho educational intervention on caregiver burden among the primary caregiver of schizophrenia clients.

The mean pretest care givers burden was 43.4% and the mean post test care givers burden was 37.11% In the pretest. 26.67% of the primary caregiver had low level care giver burden and majority of then 73.33%had high level care giver burden. Where as in the post test after family psycho educational intervention majority of primary caregiver 60% of primary caregiver had low level care givers burden, and the remaining 40% subjects had high level of caregiver burden. Post test mean is 37.11 and standard deviation was 7.15% . The difference between pretest and post test was significant at 0.05% level and this difference may be due to the family psycho educational intervention and thus it proves that family psycho educational intervention was effective in reducing the care givers Burden.

A cluster randomized controlled trial of family psycho educational intervention for families experiencing schizophrenia was conducted in Chengdu China. Treatment groups consisted family intervention and medication, medication alone and a control. The results showed a gain in knowledge, a change in the relatives caring attitude towards the patients and an increase in treatment compliance in the family psycho educational intervention group $p<0.05,0.001$.

Hence the hypothesis (H1) : There is a significant difference between the pretest level of caregiver Burden level and post test level of caregiver Burden among primary caregiver of clients with schizophrenia was accepted.

The third objective was to associate the post test level of caregiver burden among the primary caregiver of client schizophrenia clients and their selected socio demographic variables.

There was significant association between post test score with selected socio demographical variables

As per table 4 Chi-square analysis revealed that there was significant association between posttest level of caregiver Burden with educational status and occupation of the socio demographic variables among primary caregiver of clients with schizophrenia. Level of caregiver burden among primary caregiver in the post test was significantly associated with their education since the calculated value 9.84 was greater than table value 7.82 and also with their occupation since the calculated value 8.214 was greater than table value 7.82 at $P<0.05$. All other variables were not significantly associated among the primary caregiver with their post test score of caregiver burden.

Hence the hypothesis (H2) : There is a significant association between the post test level of caregiver burden scores of primary caregiver with their selected socio demographic variables. The study results found that there was an association between the post test level of caregiver burden with their education and occupation was accepted.

CHAPTER – VI

SUMMARY, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

This chapter deals with the summary of the study and conclusions drawn. It also clarifies the limitations of the study, the implications for different areas like nursing educations, administration, nursing practice, nursing research and recommendations.

6.1 SUMMARY

The present study was aimed to assess the effectiveness of family psycho educational intervention on caregiver burden among primary caregiver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai."

The objectives of the study were

1. To assess the pretest level of caregiver burden among primary caregiver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai .
2. To evaluate the effectiveness of family psycho educational intervention on caregiver burden among the primary caregiver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai .
3. To associate the post test level of caregiver burden among the primary caregiver of schizophrenia clients with selected socio demographic variables.

The following hypotheses were tested.

H_1 : There is a significant difference between the mean pretest score and mean post test caregiver burden among primary caregiver of schizophrenia Clients.

There was highly significant difference between pretest score and post test score of caregiver burden level

H_2: There is a significant association between the post test level of caregiver burden with selected socio demographic variables among primary care givers of schizophrenia.

The conceptual framework selected for this research study was based on **Imogene M. King's Goal attainment theory "Transaction model".** A pre experimental one group pre test and post test research design was used in this study. The independent variable was family psycho educational intervention and dependent variable was care givers burden. The pretest study was conducted at Government Rajaji Hospital Madurai .The accessible population of the study were primary care givers of schizophrenic clients admitted at the above hospital.

The study subjects were selected using purposive sampling.

The data collection tools used were

1. Socio demographic Data.
2. Care givers Burden Scale

Content validity was obtained from 3 Nursing experts and 2 Professor of psychiatric department. Expert's suggestions were incorporated in the tool.

A pilot study was conducted at above hospital for a period of 7 days . About 10 subjects were selected using purposive sampling. The finding suggested that the study was feasible and practicable . After obtaining the formal permission from Institutional Review Board / Independent Ethical Committee of Government Rajaji Hospital, Madurai-20 The data collection was done for a period of 4 weeks. Based on the objectives and hypotheses, the data collected were analyzed by using descriptive and inferential statistics.

6.2 MAJOR FINDINGS OF THE STUDY

- Majority of the subjects 48 (80%) were 41-50 years of age group and 11(18.33%) were 51-60 years of age group and 1(1.67%) were 20-30 years of age group. None of them were 60 years and above.

- Majority of the participants 32 (53.33 %) had no formal education and 28 (46.67%) had studied up to primary education none of them were higher secondary or graduate and above .
- All 60 (100 %) participants hailed from urban area none of them from rural or semi urban.
- Majority of the subjects 59 (98.33%) were labor and 1 (1.67%) were working in Government organizations.
- Majority of the subject's 38 (63.33%) monthly income were less than Rs.2000 and 22 (36.67 %) were earning up to Rs2001-5000 per month.
- Majority of the subjects 57 (95%) of subjects were married, 1 (1.67%) were unmarried and 2 (3.33%) were divorced.
- All participants (100 %) were Hindus. None of them were Muslim or Christian religion.

- Majority of subjects 27 (45%) had two children, 16 (26.67%) of subjects had one child, 10 (16.7%) had more than three children and 7 (11.67%) had no issue.
- Majority care givers of schizophrenia 41 (68.33%) were living in nuclear family while 14 (23.33%)were living in joint family and 5 (8.33%) were living in extended family.
- Majority of subjects 20 (33.3%) duration of illness for less than 1 year period, 13 (21.67%) for l-3 years,18 (30%) for 3-5 years of period and 9 (15%) for more than 5 years.
- In the posttest 26.67% of the primary caregiver had low level care giver burden and majority of then 73.33%had high level care giver burden. Where as in the post test after family psycho educational intervention majority of primary caregiver 60% of primary caregiver had low level care givers burden, and the remaining 40% participant had high level of caregiver burden.

The Mean Pre test and Post test was 43.48 and 37.12 respectively and Standard Deviation was 8.49 and 7.15 respectively. The Mean difference was 6.37. The paired "t" test value was 13.11. The Calculated value was greater than the table value (2.000), there was a significant difference between the pre test and post test caregiver burden level, this difference might be due to the family psycho educational intervention also this difference was purely by chance and not by choice. Hence it was inferred that family psycho educational intervention was effective on caregiver burden levels among the primary caregiver of clients with schizophrenia.

The association between selected socio demographic variables and post test score of caregiver burden among the primary caregiver of schizophrenia clients were calculated by $\chi 2$ at 0.05 level of significance. It described the relationship of an

individual socio demographic variable with level of caregiver burden among the primary caregiver of schizophrenia clients. Level of caregiver burden among primary caregiver in the post test was significantly associated with their education since the calculated value 9.84 was greater than table value 7.82 and also with their occupation since the calculated value 8.214 was greater than table value 7.82 at $P<0.05$. All other variables were not significantly associated among the primary caregiver with their post test score of caregiver burden.

It explained that there was no significant association between post test levels of caregiver burden score with individual socio demographic variables except their education and occupation. Thus the research hypothesis "there will be a significant association between post test score of level of caregiver burden and selected socio demographic variables among primary caregiver of clients with schizophrenia" was rejected except their education and occupation. Only the education and occupation variables has significant association in post test score of care givers burden with schizophrenia clients

6.3 CONCLUSION

According to the results of this study, primary care giver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai who adopted family psycho educational intervention for 45 minutes had a statistically significant in reducing care giver burden. Because family psycho educational intervention techniques were non invasive, free from side effects and highly feasible, the researcher concluded that it can be used as an effective intervention to reduce care giver burden which enhance the care activities to the care givers ,and improve the wellbeing of the caregiver.

6.4 IMPLICATIONS

The investigator had drawn implications from this study for various areas such as nursing practice, nursing education, nursing administration and nursing research.

Implications for Nursing Practice

1. The nurses must be trained to assess the care giver burden among primary care giver so as to reduce the burnout and take necessary initial steps in post venting caregiver Burden.

2. The findings of the study will throw light on the need to provide non pharmacological, cost effective approach to reduce care giver burden these by promoting their self esteem.

3. The nurses should educate about the benefits of family psycho educational intervention and encourage to practicing among the primary care giver and significant other..

Implications for Nursing Education

1. The concepts of family psycho educational intervention regarding care giver burden should be included in the nursing curriculum of Undergraduate and Postgraduate programme.

2. A well organized Continuing Nursing Education programme that focuses on family psycho educational intervention regarding care giver burden can be conducted among nursing personnel in the hospital set up as well as in the community.

Implications for Nursing Administration

1. Health education team can be formed to improve the usage of family psycho educational intervention regarding care giver burden

2. The nurse administrators can motivate, supervise and guide the nurses in family psycho educational intervention regarding care giver burden and they need to formulates policies and protocols for caring client with schizophrenia.

3. Nurse administrators can prepare own assessment tools to assess caregiver Burden.

Implications for Nursing Research

1. The nurse researcher should motivate the clinical nurses and community nurse to apply research findings to reduce the care giver burden in any set up.
2. The nurse researcher should encourage clinical nurse to conduct further Research studies on the effectiveness of family psycho educational intervention regarding care giver burden
3. This study can be used as a baseline for further future studies to build upon.

6.5 RECOMMENDATIONS

1. This study can be replicated with a large sample size for better generalization.
2. A comparative study can be done between selected family psycho educational intervention regarding care giver burden and other complimentary therapy.
3. Investigator recommends the hospital authority to regular practice of family psycho educational intervention regarding care giver burden among primary care giver

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APPENDIX - A

LETTER SEEKING PERMISSION TO CONDUCT STUDY

From

V.Sumathi
M.sc (N) II Year
College of Nursing, Madurai Medical College
Madurai -20

To

The Head of the Department
Department of Psychiatry
Government Rajaji Hospital
Madurai – 20

Through the principal ,college of Nursing ,Madurai Medical College, Madurai

Respected Sir,

Sub : Requesting permission to conduct the dissertation study at Psychiatry Ward Government Rajaji Hospital, Madurai – regarding

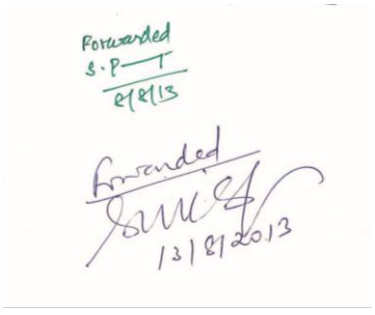
As per the curriculum recommended by the Indian nursing council and the Tamil Nadu Dr.MGR Medical University, all the M.sc (N) students are required to conduct a dissertation study the partial fulfillment of the course.

I select the topic "A study to assess the effectiveness of family psycho educational intervention on caregiver burden among primary caregiver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai." for my dissertation

I Kindly request you to consider my letter and allow me to conduct the study in the ward along with your needful opinion regarding the study.

Thanking you,

Place: Madurai Yours sincerely
Date:



APPENDIX-B

ETHICAL COMMITTEE APPROVAL LETTER

Ref. No. 9101/E4/3/2013 **Govt Rajaji Hospital,**
Madurai-20. Dated: 20.09.2013

Institutional Review Board I independent Ethics Committee,
Dr. N. Mohan, MS., F.LC.S F.A.I.S.,
Dean, Madurai Medical College &
Govt Rajaji Hospital, Madurai 625020. **Convener.**

Sub: Establishment-Govt. Rajaji Hospital. Madurai-20-
Ethics committee-Meeting Minutes- for August 2013
Approved list -regarding.

The Ethics Committee meeting of the Govt. Rajaji Hospital, Madurai was held on 08.08,2013, Wednesday at 10.00 am to 12.00.pm at the Anesthesia Seminar Hail, Govt. Rajaji Hospital, Madurai. The following members of the committee have attended the meeting.

I Dr. V, Nagarajan, M.D., D.M (Neuro) Ph: 0452-2629629 Cell.No 9843052029	Professor of Neurology (Retired) D.No.72, Vakkil New Street, Simmakkal, Madurai -1	Chairman
2. Dr.Mohan Prasad. MS M.Ch Cell,No.9843050822 (Oncology)	Professor & H.O.D of Surgical Oncology(Retired) D.No.72, West Avani Moola Street. Madurai -1	Member Secretary
3. Dr. I. Jeyaraj, M.S... (Anatomy) Cell.No 9566211947	Director & Professor Institute of Anatomy /V,P Madurai Medical College	Member
4. Dr. Parameswari M.D (Pharmacology) Cell.No.9994026056	Director of Pharmacology Madurai Medical College	Member
5. Dr.S. Vadivel Murugan, MD., (Gen.Medicine) Cell.No 9566543048	Professor of Medicine Madurai Medical College	Member
6. Dr.S. Meenakshi Sundaram, MS (Gen.Surgery) Cell.No 9842138031	Professor & H.O.D of Surgery i/c Madurai Medical College	Member
7. Miss, Mercy Immaculate Rubalatha, MA., Med,, Cell. No. 9367792650	50/5, Corporation Officer's quarters, Gandhi Museum Road, Thamukam, Madurai-20	Member
8. Thiru. .Pala. .Ramasamy , BA.,B.L.,Cell.No 9842165127	Advocate, D.No,72.Palam Station Road, Sellur, Madurai -2	Member

9. Thiru. P.K.M. Chelliah,B.A Businessman, 21 Jawahar Street.
Cell.No 9894349599 Gandhi Nagar, Madurai-20 Member

The following Projects were approved by the committee

S.No	Name of P.G	Course	Name of the Project	Remarks
1.	V. SUMATHI	M.Sc Nursing in Mental health (Psychiatric Nursing) Govt. Rajaji Hospital, Madurai	A study to assess the effectiveness of family psycho educational intervention on caregiver burden among primary caregiver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai	Approved

Please note that the investigator should adhere the following: She / He should get a detailed informed consent from the patients/participants and maintain it confidentially.

1.She / he should carry out the work without detrimental to regular activities as well as without extra expenditure to the institution or to Government,

2. She/he should inform the institution Ethical Committee, in case of any change of study procedure, site and investigation or guide.

3. She / He should not deviate the area of the work for which applied for Ethical clearance, She / He should inform the JEC immediately, in case of any adverse events or Serious adverse reactions.

4, She / He should abide to the rules and regulations of the institution,

5. She / He should complete the work within the specific period and if any Extension of time is required He / She should apply for permission again and do the work,

6. She / He should submit the summary of the work to the Ethical Committee on Completion of the work.

7. She / He should not claim any funds from the institution while doing the work or on completion.

8. She / He should understand that the members of IEC have the right to monitor the work with prior intimation.

Member Secretary **Chairman**
Ethical Committee

DEAN/Convenor
Govt. Rajaji Hospital,
Madurai- 20.

20/9/13

To
The above Applicants
-thro. Head of the Department concerned

APPENDIX-C

LETTER SEEKING EXPERT SUGGESTION AND CONTENT VALIDATION

CERTIFICATE OF VALIDATION

This is to certify that the tool

SECTION A- Demographic Data

SECTION B- Distress Tolerance Scale

Prepared for data collection by **V.Sumathi**, II Year M.Sc (N) student, College of Nursing, Madurai Medical College, Madurai, who has undertaken the study field on thesis entitled **"A study to assess the effectiveness of family psycho educational intervention on caregiver burden among primary caregiver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai."** has been validated by me.

SIGNATURE OF THE EXPERT

NAME:

DESIGNATION:

DATE:

APPENDIX - D

CONTENT VALIDITY CERTIFICATE

SECTION A- Demographic Data

SECTION B- Distress Tolerance Scale

Prepared for data collection by **V.Sumathi**, II Year M.Sc (N) student, College of Nursing, Madurai Medical College, Madurai, who has undertaken the study field on thesis entitled **"A study to assess the effectiveness of family psycho educational intervention on caregiver burden among primary caregiver of schizophrenia clients admitted in Government Rajaji Hospital at Madurai."** has been validated by me.

S. Jeeva 28/8/13.

SIGNATURE OF THE EXPERT

NAME: DR. S. JEEVA CREEDOM VICTORY

DESIGNATION CIVIL ASSISTANT SURGEON

DATE: 28/8/13

DR. S. JEEVA, M.B.B.S..D.P.M..
PSYCHIATRIST & ASSISTANT SURGEON
REG No 56852
TIRUNELVELI MEDICAL COLLEGE HOSPITAL
TIRUNELVELI - 11

CERTIFTICATE OF VALIDATION

This is to certify that the tool

SECTION A- Demographic Data

SECTION B- Caregiver burden scale

Prepared for data collection by V. Sumathi, II Year M.sc (N) student, College of Nursing, Madurai Medical college, Madurai, who has undertaken the study field on thesis entitled **"A Study to assess the effectiveness of Family psycho educational intervention on care giver burden among primary care giver of schizophrenia clients admitted in psychiatry ward at Government Rajaji hospital Madurai – 20.** Has been validated by me.

SIGNATURE OF THE EXPERT

NAME: Dr. T. KUMARAN, MD., DPM

DESIGNATION: PROFESSOR OF PSYCHIATRY,

DATE 21.1.2014

CERTIFTICATE OF VALIDATION

This is to certify that the tool

SECTION A- Demographic Data

SECTION B- Caregiver burden scale

Prepared for data collection by V. Sumathi, II Year M.sc (N) student, College of Nursing, Madurai Medical college, Madurai, who has undertaken the study field on thesis entitled **"A Study to assess the effectiveness of Family psycho educational intervention on care giver burden among primary care giver of schizophrenia clients admitted in psychiatry ward at Government Rajaji hospital Madurai – 20**. Has been validated by me.

9/9/13

SIGNATURE OF THE EXPERT

NAME: Mrs. RUFA MITSU. J

DESIGNATION: Reader

DATE: 9/9/13

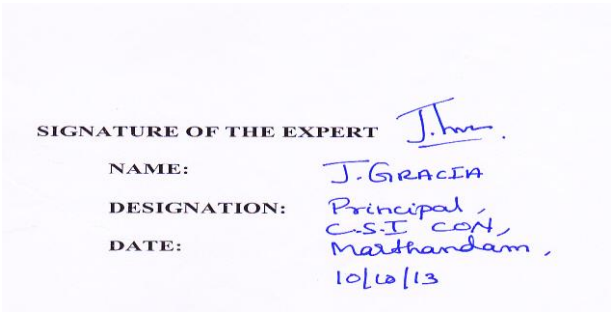
CERTIFTICATE OF VALIDATION

This is to certify that the tool

SECTION A- Demographic Data

SECTION B- Caregiver burden scale

Prepared for data collection by V. Sumathi, II Year M.sc (N) student, College of Nursing, Madurai Medical college, Madurai, who has undertaken the study field on thesis entitled **"A Study to assess the effectiveness of Family psycho educational intervention on care giver burden among primary care giver of schizophrenia clients admitted in psychiatry ward at Government Rajaji hospital Madurai – 20**. Has been validated by me.



CERTIFTICATE OF VALIDATION

This is to certify that the tool

SECTION A- Demographic Data

SECTION B- Caregiver burden scale

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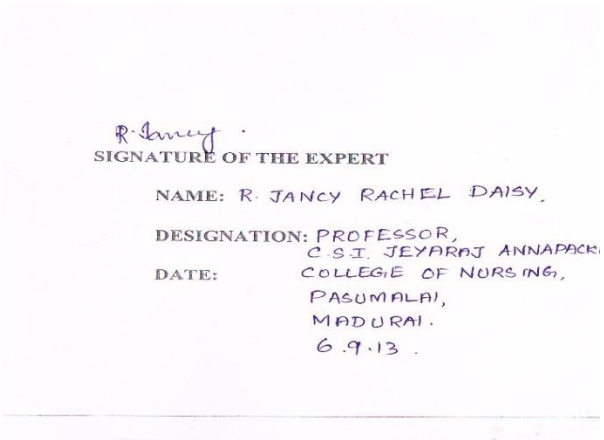

R. Jancy

SIGNATURE OF THE EXPERT

NAME: R. JANCY RACHEL DAISY,

DESIGNATION: PROFESSOR,
C.S.I. JEYARAJ ANNAPACK
COLLEGE OF NURSING,
PASUMALAI,
MADURAI.

DATE: 6.9.13.

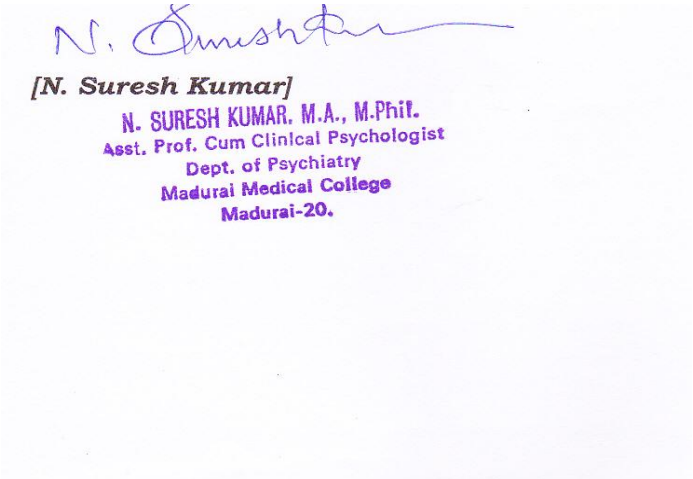
CERTIFTICATE OF VALIDATION

This is to certify that the tool

SECTION A- Demographic Data

SECTION B- Caregiver burden scale

Prepared for data collection by V. Sumathi, II Year M.sc (N) student, College of Nursing, Madurai Medical college, Madurai, who has undertaken the study field on thesis entitled **"A Study to assess the effectiveness of Family psycho educational intervention on care giver burden among primary care giver of schizophrenia clients admitted in psychiatry ward at Government Rajaji hospital Madurai – 20.** Has been validated by me.



APPENDIX - E

INFORMED CONSENT FORM

Xg;Gjy; mwpf;if

ngah;: **ehs;:**

vdf;F ,e;j nrtpypa Ma;tpidg; gw;wpa KO tptuk; tpsf;fkhf vLj;Jiuf;fg;gl;lJ. ,e;j Ma;tpy; gq;Fnfhs;tjpy; cs;s ed;ikfs; kw;Wk; jPikfs; gw;wp KOikahf Ghpe;Jnfhz;Nld;. ,e;j Ma;tpy; jhdhf Kd;te;J gq;FngWfpNwd;. NkYk; vdf;F ,e;j Ma;tp;ypUe;J ve;j rkaj;jpYk; tpyfpf;nfhs;s KO mDkjp toq;fg;gl;Ls;sJ. vd;Dila rpfpr;ir Mtzq;fis ghh;itapl;L mjpy; cs;s tptuq;fis Ma;tpy; gad;gLj;jpf;nfhs;s KO mDkjp mspf;fpNwd;. vd;Dila ngah; kw;Wk; milahsq;fs; ufrpakhf itj;Jf; nfhs;sg;gLk; vd;Wk; vdf;F cWjpaspf;fg;gl;Ls;sJ.

ifnahg;gk;.

APPENDIX - F

SECTION - I

DISTRIBUTION OF DEMOGRAPHIC VARIABLE

TABLE NO 1

1. AGE

a. 20-30 years ☐

b. 31-40 years ☐

c. 41- 50 years ☐

d. 51-60 years ☐

e. 61yrs and above

2. EDUCATION

a. Non Formal education ☐

b. Primary ☐

c. High School ☐

d. Higher Secondary ☐

e. Degree ☐

3. DOMICILE

a. Urban ☐

b. Rural ☐

c. Sub Urban ☐

4. OCCUPATION

a. Labour ☐

b. Govt. ☐

c. Private ☐

d. Self Employment ☐

5. TOTAL INCOME OF FAMILY

a. < 2000 ☐

b. 2001-5000 ☐

c. 5001-10000 ☐

d. > 10000 ☐

6. MARITAL STATUS

a. Unmarried ☐

b. Married ☐

c. Divorced ☐

d. Separated ☐

7. RELIGION

a. Hindu ☐

b. Christian ☐

c. Muslim ☐

d. Others ☐

8. NO OF CHILDREN

a. No issue ☐

b. one child ☐

c. Two children ☐

d. >3 children ☐

9. TYPE OF FAMILY

a. Nuclear Family ☐

b. Joint Family ☐

c. Extended Family ☐

10. DURATION OF ILLNESS

a. < 1Years ☐

b. 1-3 Years ☐

c. 4-5 Years ☐

d. .>5 Years ☐

SECTION - B

NAME: **CARE GIVER BURDEN SCALE**

S.no	content	Not at all	To some extent	verymuch
1	Do you think that your family appreciates the way care for the patient?	3	2	1
2.	Does the patient's illness prevent you from having a satisfying relationship with rest of your family?	1	2	3
3.	Does your spouse help with family responsibilities?	3	2	1
4.	Is your spouse still affectionate towards you?	3	2	1
5.	Is your spouse able to satisfy your needs fore intimacy?	3	2	1
6.	Has the quality of your marital relationship declined since your spouse's illness?	1	2	3
7.	Does caring for the patient make you feel tired and exhausted?	1	2	3
8.	Do you think that your has been affected because of the patient's illnesss?	1	2	3
9.	Do you sometimes feel depressed and anxious because of the patient?	1	2	3
10.	Do you sometimes feel that there is no solution to your problems?	1	2	3
11.	Has your family stability been disrupted by the patient's illness(frequent quarrels,break up)?	1	2	3
12	Does the patient cause disturbances in the home?	1	2	3
13	Are you able to care enough for others in your family?	3	2	1
14	Have you started to feel lonely and isolated since the patient's illness?	1	2	3
15	Does the patient's unpredictable behavior disturb you?	1	2	3
16	Do you feel that your friends	3	2	1

	appreciate the way you care for the patient?			
17	Does the patient's illness prevent you from having satisfying relationship with your friends?	1	2	3
18	Do you often feel frustrated that the improvement of the patient is slow/there is no improvement at all?	1	2	3
19.	Do you have the feeling that the patient understands and appreciates your effort to help him/her?	3	2	1
20	Is the patient's illness preventing you from looking for a job?	1	2	3

SCORING PROCEDURE

Section B: Caregiver burden scale (CG'BS by R.THARA 1995 WHO)

Section B: Caregiver burden scale (CG'BS) – a 20 item questionnaire rated on a 3 point scale:

- Scores were calculated as followed negative items;1,3,4,5,13,16,19 (3) not at all ,(2)to some extent (1)very much are scored in reverse in valent.
- The positive items ;2,6,7,8,9,10,11,12,14,15,17,18,20 (1)not at all (2)to some extent(3)very much are scored in reverse in valent.

SCORING:

Level of scoring	Interposttation
HIGHER IN VALUE	40<60
LOWER IN VALUE	20<41

APPENDIX-G

gphpT- m

r%f Fbapay; Fwpg;G

1.taJ [ ]

m).20-30 tiu

M).31-40 tiu

,).41-50 tiu

<).51-60 tiu

c).61 kw;Wk; mjw;F Nky;

2.fy;tpj;jFjp [ ]

m).gbf;fhjth;

M).Muk;gf;fy;tp (1-5 k; tFg;G)

,).cah; epiyf;fy;tp

<).Nky;epiyf;fy;tp

c).gl;lg;gbg;G kw;Wk; mjw;F Nky;

3. ,Ug;gplk;; [ ]

m).efuk;

M).fpuhkk;;

,).Gw efuk;

4. njhopy; ; [ ]

m).jdpahh; Copah;

M).muR Copah;

,).$ypj;njhopy;

<).Ranjhopy

5. FLk;g khj tUkhdk; [ ]

m).&gha; 2000-j;jpw;Fs;;

M).&2001-&5000 tiu

,).&5001-10000 tiu

<).&10000w;F Nky; ;

6.jpUkzk; gw;wpa tptuk;

[ ]

m).jpUkzk; Mfhjth;

M).jpUkzk; Mdth;

,).Tpthfuj;jhdth;

<).Gphpe;J tho;gth;

7.; kjk;

[ ]

m).;;,e;J

M).fpwp];jth;

,).;K];ypk;

<).Gpw kjk;

8. Foe;ijfspd; vz;zpf;if

[ ]

m).Foe;ij ,y;yhjth;

M).xU Foe;ij

,).,U Foe;ijfs;

<).%d;W Foe;ijfSf;F Nky;

c).jpUkzk; Mfhjth;

9.; FLk;gj;jpd; jd;ik

[ ]

m).jdpf;FLk;gk

M).$l;L FLk;gk;

,).tphpthf;fg;gl;l FLk;gk;

10. Fbg;gof;fk; vj;jid Mz;Lfshf cs;sJ [ ]

m).5 tUlq;fSf;Fs;shf

M).6 - 10 tUlk;

,).11 – 15 tUlk;

<).16 – 20 tUlk;

c).21 tUlk; kw;Wk; mjw;F Nkyhf

மனபாரம் அளவிடும் அட்டவணை

வ.எண்	பொருளடக்கம்	ஒரு போதும்இல்லை	அவ்வப்போது	எ
1.	உங்களின் குடும்பம் நீங்கள் நோயாளியை கவனித்துக்கொள்வதை பாராட்டுகிறதா?			
2.	நோயாளியின் நோய் குடும்பத்தில் உள்ள மற்றவரிடம் அன்பு பாராட்டுவதை தடுக்கிறதா?			
3.	உங்கள் துணை குடும்ப பாரத்தை பகிர்ந்து கொள்கிறாரா?			
4.	உங்கள் துணை உங்களிடம் அன்பு paraatukiraaraaபாராட்டுகிறாரா?			
5.	உங்களது அந்தரங்க தேவைகளை பூர்த்தி செய்கிறாரா?			
6.	உங்களின் குடும்ப வாழ்க்கை தரம் துணைவரின் நோயினால் குறைந்துள்ளதா?			
7.	நோயாளியை கவனித்துக்கொள்வதால் நீங்கள் அயர்ந்துவிடுகிறீர்களா?			
8.	நோயாளியின் நோயால் உங்களது உடல்நலம் பாதிக்கபடுவதாக நினைக்கிறீர்களா?			

9.	நோயாளியினால் நீங்கள் சிலசமயம் மனஅழுத்தம் மற்றும் கவலை அடைகிறீர்களா?			
10.	உங்களது பிரச்னைகளுக்கு தீர்வே இல்லையென சிலசமயம் நினைக்கிறீர்களா?			
11.	நோயாளியின் நோயினால் உங்கள் குடும்பத்தின் ஸ்திரத்தன்மை பாதிக்கப்படுகிறதா?			
12.	நோயாளி வீட்டில் பிரச்னை எற்படுத்துகிறாரா?			
13.	குடும்பத்தில் உள்ள மற்றவர்களை நன்கு கவனிக்க முடிகிறதா?			
14.	உங்களின் நண்பர்கள் நீங்கள் நோயாளியை பார்த்துக்கொள்ளும் விதத்தை paaraatukinranaraaaபாராட்டுகின்றனரா?			
15.	நோயாளியின் எதிர்பார்க்க முடியாத செயல்களால் பாதிக்கப்படுகிரீர்களா?			
16.	நோயாளிக்கு நோய் வந்தபின் நீங்கள் தனிமைப்படுத்தப்பட்டதாக உணர்கிறீர்களா?			
17.	நோயாளின் நோயால் உங்கள்			

	நண்பர்களுடன் திருப்தியாக நட்பு பாராட்ட முடியவில்லை யா?			
18.	நோயாளியிடம் எந்த முன்னேற்றம் இல்லை என அடிக்கடி நினைப்பது உண்டோ?			
19.	நோயாளி தங்களின் சேவையை புரிந்து பாராட்டுவதாக உணருகிறிர்களா?			
20.	நோயாளியின் நோய் உங்களுக் கென்ன ஒரு வேலையைத் தேடிக் கொள்வதைத் தடுக்கிறதா?			

APPENDIX- I

CERTIFTICATE OF ENGLISH EDITING

TO WHOM SO EVER IT MAYCONCERN

This is to certify that the dissertation " **A Study to assess the effectiveness of Family psycho educational intervention on care giver burden among primary care giver of schizophrenia clients admitted in psychiatry ward at Government Rajaji hospital Madurai "done by V.SUMATHI** II Year M.sc (N) student, College of Nursing, Madurai Medical college, Madurai -20 has been edited for English language appropriateness.

APPENDIX- H

CERTIFICATE OF TAMIL EDITING

TO WHOM SO EVER IT MAY CONCERN

This is to certify that the dissertation " **A Study to assess the effectiveness of Family psychoeducational intervention on care give r burder among primary care giver of schizophrenia clients admitted in psychiatry ward at Government Rajaji hospital Madurai "done by V.SUMATHI** II Year M.sc (N) student, College of Nursing, Madurai Medical college, Madurai -20 has been edited for Tamil language appropriatness.

APPENDIX-J

FAMILY PSYCHO EDUCATIONAL INTERVENTION

FAMILY PSYCHO EDUCATIONAL INTERVENTION

CONTENTS

- THE CAUSES, SYMPTOMS OF SCHIZOPHRENIA,
- THE IMPORTANCE OF TREATMENT, RELAPSE AND RELAPSE PREVENTION
- THE COMMUNICATION SKILLS IN THE FAMILY
- MANAGEMENT OF CLIENTS PROBLEM SOLVING SKILLS
- EFFECTIVE WAY TO EXPRESS EMOTION
- EDUCATE CARE GIVERS TO RELAXATION METHODS IN THE FAMILY

SCHIZOPHRENIA

It is a mental illness

- Schizophrenia is not a rare illness-1/ 100 people suffer from it during their lifetime. It starts mainly in young people between the ages of 15 and 30. It may occur at any time□□Both men and women can suffer from it.

Causes, Symptoms

Symptoms:

Affected members will have symptoms due to the illness (positive symptoms) such as (give examples of the affected member's hallucinations, delusions, etc). Qualities taken away by the illness are called negative symptoms (give examples of affected member's lack of drive, motivation, etc). They may have Language difficulties such as talking in a way hard to follow, making up new words, using odd expressions, or speaking very little. They may also have Odd habits like…. (Give examples of affected member's peculiar mannerisms or habits, standing or sitting in unusual ways). □□They may also show Changed feelings and emotions such as little

or no emotions, not show normal affection for family and friends, laugh or cry when they are not feeling happy or sad.

2**. Course:**

Most will get better with treatment. About one in four people have an attack from which they make a complete recovery and then stay well for years. A small number do not respond to treatment and will have symptoms all the time. Affected members can have relapses. Between attacks, they may not be the same way they were before (give examples of negative symptoms). These are partly the result of the medication, partly due to the illness itself and partly due to the affected member's, own attempts to avoid becoming upset and ill again. Some of these improve particularly if the family can manage to be supportive and encouraging.

Causes of Schizophrenia

Genetic

Schizophrenia can be inherited. This does not mean that the affected member should not have children in case they will be affected. It does not mean that if one family member gets it, the others will also. If your close relative like a sibling or parent suffers from it, then your chances of getting it are higher Schizophrenia can also occur when there are no other relatives who have it. It is not the illness that is inherited but the tendency to get it. No clear genetic pattern has been found for schizophrenia

2) **Imbalance of brain chemistry**

Schizophrenia is probably caused by a disturbance in the working of the brain. Chemicals in the brain are affected and this produces the symptoms of hallucinations, delusions and thinking difficulties. Dopamine is the name of one of the many chemicals in the brain. Too much dopamine may be produced in those with schizophrenia. Certain medication improves the symptoms of schizophrenia-these are made up of chemicals. It is thought that these help to balance the chemicals in the brain.

MEDICATIONS AND COMPLIANCE

A review of previous session

Medication is the **main** form of treatment. Medical treatment does not **cure** the illness. Medication is used to **reduce** the symptoms & to **prevent** further attacks, or the symptoms getting worse. Some people recover well and are able to lead normal lives. Most need to stay on medication for a **longtime**, sometimes the rest of their lives. The medications are not **addictive.** There are several **types** of drugs used with different brand names, in the form of **tablets or injections**. The medications work by blocking the transmission of **dopamine**. **Negative symptoms** are often not improved by medication. The **effects** are not always seen immediately. The medication have to be taken **regularly** (even when they feel well) to prevent further attacks and remain well. There is a high risk of **relapse** in the first year associated with stopping medication. Even for those taking medication regularly the risk of relapse is about 20%. The medication can sometimes produce unwanted **side effects**. These are not usually serious can should be discussed with your doctor. Reducing the dose may get rid of these side effects, or they may need to take another tablet which acts as an antidote. Sometimes changing from one type of medication to another will relieve

side effects. ECT's may be indicated for catatonic patients and for patients who for some reason cannot take anti-psychotics

Some of the side effects are:

_ Drowsiness

_ Restlessness

_ Muscle stiffness

_ Shakiness

_ Sensitivity to sunburn

_ Increased appetite

_ Dizziness when standing up suddenly

Relapse and relapse prevention

Reducing the dose may get rid of these side effects, or they may need to take another tablet which acts as an antidote. Sometimes changing from one type of medication to another will relieve side effects. Some of these effects can be avoided by avoiding too much sun, standing up slowly and watching their diet. Electroconvulsive therapy (ECT) may be indicated for catatonic patients. Review with the family the significance and meaning of possible warning signals. Signals differ from patient to patient. Inform the family that there are numerous warning signs. These help in avoiding another episode or hospitalization. Advise the family to observe whether these warning signs are fleeting or are present continuously for at least a week and/ or appear to be increasing. If the latter, the family should consult the treating team Some warning signals for the family to look out for are: alterations in routine habits (like sleeping and eating), becoming easily irritable, muttering to self, changes in personality or

- bizarre behaviour.
- Explain the family role in relapse prevention
- Educate on importance of follow up care
- Exploration of family intervention When relapse occurred
- Role of environmental stress as a risk factor for schizophrenia relapse

COMMUNICATION SKILLS IN THE FAMILY

- A review of previous session
- **Discuss on**
- Communication

Discourage family from speaking for the affected member. Family members have to wait for the affected member's response. Use social conversation and problem solving as practice. Observe how they speak, reinforce correct behavior and encourage improvement on other areas. Demonstrate how to reframe sentences. Give homework assignments and review in next session. Negotiate daily activities, household chores and family roles. Discourage family members from ignoring, reinterpreting or trying to make sense of unclear messages from the affected members. Inform them that tolerating poor communication gives the message that affected members need not learn to be clear in interactions with others. Encourage the families to say that they do not understand what the affected member is saying or that it was unclear and could the affected member repeat what he had said.

PROBLEM SOLVING SKILLS

- A review of previous session
- **Discuss on**

Inability to sleep; day/night reversal Social withdrawal, isolation, fear and suspicion Skipping classes/ not going to work; avoiding going out Inability to concentrate, staring, vagueness drug or alcohol abuse; repetitive actions, food fads deterioration in personal hygiene; eccentric dress frequent moves or trips or long walks leading nowhere unusual sensitivity to stimuli (noise, light); low tolerance to irritation undue preoccupation with spiritual or religious matters Bizarre behavior Conversation that does not make sense-very abstract, seemingly deep but not logical or coherent; obsessed with one idea.

Coping skills

- Token economy
- Positive reinforcement
- Tackling the symptoms
- Cope with clients according to their needs
- Respect the clients
- Approach freely when with problem

CARE GIVERS RELAXATION TECHNIQUE

- A review of previous session
- **Teach relaxation technique to the care giver**

kdeyf; fy;tp

மனநலக் கல்வி

மனநலக் கல்வி

1. மனச்சிதைவு நோயின் காரணங்கள் அறிகுறிகள் வகைகள்
2. மனச்சிதைவு நோயின் மருத்துவ சிகிச்சை முறைகள் மீண்டும் மருத்துவ சிகிச்சை முறைகள் தவிர்த்தல்
3. தகவல் தொடர்பு திறன்
4. பிரச்சினைகள் தீர்வு திறன்
5. உணர்வு வெளிப்பாடு
6. தளர்வு பயிற்சி

1. மனச்சிதைவு நோய் என்றால் என்ன?

மனச்சிதைவு நோய் என்பது மூளையில் ஏற்படும் இரசாயன மாற்றத்தால் சிந்திக்கும் தன்மை பழுது ஏற்பட்டு கட்டுப்பாடற்று செயல்படுவது மனசிதைவு நோய் ஆகும்.

2. மனச்சிதைவு நோயின் காரணங்கள்:

☐ மனச்சிதைவு நோய் ஆண், பெண், இன, மத, மொழி, சமுதாய கலாச்சாரா பேதமின்றி அனைத்து தரப்பினரையும் பாதிக்கும்.

☐ பெரும்பாலும் 15 வயது 45 வயதிற்கு உட்பட்டோர் இந்த வகை நோயினால் பாதிக்கப்படுகின்றனர்.

☐ இதற்கான மூலக்காரணத்தை உடல்நோய்கள் போல் உறுதியாக கூற முடியாது.

☐ தற்பொழுது நவீன விஞ்ஞான ஆராய்ச்சிகளின் மூலம் மூளையில் ஏற்படும் சில இரசாயன மாறுதல்களினால் இந்நோய் ஏற்படலாம்.

☐ மூளையிலுள்ள டோமைன், செரடோனின் மாற்றங்களினால் மனச்சிதைவு, நோயாளியின் ஆளுமை திறன் பாதிக்கப் படுகிறது.

☐ வெகு சிலருக்கு பரம்பரை ரீதியாகவும் இந்நோய் ஏற்படலாம்.

☐ குடும்பத்தில் ஒருவர் மனச்சிதைவு நோயினால் பாதிக்கப்பட்டு இருந்தால், இரத்தத் தொடர்பான உறவினர்களுக்கு வர வாய்ப்புகள் அதிகம். அதாவது, பெற்றோருக்கு 5% சகோதரிகளுக்கு 9% குழந்தைகளுக்கு 12% முதல் 36% மற்ற உறவினர்களுக்கு 3% வாய்ப்புள்ளது.

☐ வெகு நாட்கள் மது அருந்துவதாலும், கஞ்சா, அபின் மற்றும் பல்வேறு வகையான போதைப் பொருள்களை உட்கொள்வதாலும் மூளை பாதிக்கப்பட்டு மனச்சிதைவு நோய் வர வாய்ப்புள்ளது.

☐ வீட்டில் உள்ள சூழ்நிலை உகந்ததாக இல்லாவிடினும், பெரும் ந்டம், அவநம்பிக்கை, சமுதாயத்தில் மற்றவர்களால் புறக்கணிக்கப்படும போதும் மனக்கவலை ஏற்பட்டு அதனால் மனச்சிதைவு நோய் ஏற்படும் வாய்ப்புகள் அதிகம்.

3. மனச்சிதைவு நோயின் அறிகுறி

மனச்சிதைவு நோயினால் பாதிக்கப்படுபவர்கள் காரணம் இல்லாமல்

- அடிக்கடி நோய், எரிச்சல், கவனக்குறைவு
- படபடப்பு, பயம்
- எதிலும் நம்பிக்கை இல்லாமல், ஆர்வமின்றி, தனிமையை விரும்புவது
- யோசித்து கொண்டே கற்பனையோடு இருப்பது
- சிலரிடம் செய்யும் வேலையில் அதிகம் வேகம் காணப்படும்.
- அமைதி இல்லாமல் ஏதாவது வாதம் செய்து கொண்டும் இருப்பர்.
- இன்னும் சிலர் அர்த்தமற்ற அடிப்படை இல்லாத தவறான நம்பிக்கை கொண்டவராகவும், சந்தேக எண்ணங்கள் கொண்டவராகவும் இருப்பர்.
- பாசமும், அன்பும் மிகுந்த தாய்கூட உணவில் வி'ம் கலந்து கொடுப்பதாகவும்,
- உண்மையான அன்பான மனைவியை கூட தகாத உறவு கொண்டிருப்பதாகவும் சந்தேகிப்பார்கள்.
- பொருள் இல்லாமல் பேசியதையே திரும்ப, திரும்ப பேசிக் கொண்டிருப்பார்கள்.
- சரிவரத் தூக்கம் வராமலும், எதிலும் விருப்பம் இல்லாமலும் இருப்பர்.
- அன்றாட வேலைகளையும், நேரத்திற்கு சாப்பிடாமலும் இருப்பார்கள்
- தன்னை சுற்றியுள்ளவர்கள் பேசிக் கொண்டிருந்ததாக அவர்கள் தன்னைப் பற்றித்தான் பேசிக் கொண்டிருக்கிறார்கள்.
- யாரோ தன்னுடன் பேசுவது போலவும், கிண்டல் கேலி செய்வது போலவும்
- காதில் வேறுயாரக்கும் கேட்காத மாயக்குரல்கள் கேட்பது போல இருக்கும்
- கனவுகள் காண்பதும், அது உண்மையாக நடப்பது போலவும்.
- பிறருக்கு தெரியாத காட்சிகள், மாயக்காட்சிகள் தனக்கு தெரிவதாகவும் கூறுவர்.

4. மனச்சிதைவு நோயின் வகைகளும், அறிகுறிகளும்

மனச்சிதைவு நோயைப் பலவாறாக வகைப்படுத்தினாலும், இந்த நோயைப் பற்றி சுலபமாகத் தெரிந்து கொள்ள கையாளப்பட்ட ஒரு மரபு.
ஒரு வகையில் கருதப்பட்ட நோயாளி நாளடைவில் மற்றொரு வகைக்கும் மாறுவதுண்டு.

1. குமரப்பருவ மனச்சிதைவு நோய்

- ☐ இவ்வகை நோய் குமரப்பருவத்தின் முதல் கட்டம், முதலில் சிறுகச் சிறுக துவங்கும்.
- ☐ நோயாளி அநேகமாக மணமாகாதவராகவும், வேலையற்றவராகவும் இருப்பர்.
- ☐ அவர் குடும்பத்தில் எவரேனும் ஒருவர் மனச்சிதைவினால் பாதிக்கப்பட்டு இருக்கலாம்.

அறிகுறிகள்:-

- ☐ உணர்ச்சி, சிந்தனை மழுளிகி முரண்பாடானதாகவும்,
- ☐ அசட்டுதனம், பல்லிளிப்பு, பொருளற்ற புன்னகை சிரிப்பு
- ☐ கண்ணாடி முன் நின்று அடிக்கடி தன் அழகு பார்த்து சிரிப்பது இவர்களிடம் காணப்படும் முக்கிய அறிகுறியாகும்.
- ☐ மற்றும் பேச்சு, தொடர்பில்லாமலும், அர்த்தமற்றும் இருப்பதுடன் இவர்கள் மரபில் இல்லாத புதுப்புது வார்த்தைகளாக உபயோகிப்பர்.
- ☐ இவர்களுடைய எழுத்தும், வரையும் படங்களும் பொருளற்று காணப்படும்.

விறைப்பு சார்ந்த மனச்சிதைவு நோய்

விறைப்பு சார்ந்த மௌன நிலை எனவும், உன்மந்த நிலை எனவும் இருவகையான வேறுபட்ட அறிகுறிகளுடன் காணப்படும்.

அறிகுறிகள்:- (மௌனநிலை)

- ☐ மனத்தளர்ச்சி, அதிருப்தி, மனக்கொந்தளிப்பு
- ☐ தீவிர உணர்ச்சிகள் நோயாளியைப் பாதித்த பிறகே இந்நிலை தோன்றும்.
- ☐ எதிலும் விருப்பமின்றி, கவனம் இல்லாமல் உணர்ச்சி மழுங்கி, கனவுலகில் சஞ்சரிப்பர்.
- ☐ ஊமையாக, மந்தமாக, கவனமற்ற முகத்துடன் மௌனமாகி விடுவர்.
- ☐ சிலர் கண்களை மூடிக்கொண்டும், வீட்டுத் தரையையோ, முகட்டையையோ இமை கொட்டாமல் பார்ப்பது.
- ☐ கற்சிலைபோல் ஒரு நாள் முழுவதும் கூட அசையாமல் நிற்பது
- ☐ சிலர் நாற்காலியின் விளிம்பில் (அல்லது) தரையில் பதுங்கிய நிலையில் பல மணிநேரம் அசையாமல் இருப்பர்.
- ☐ சுற்றுச்சூழ்நிலையை புறக்கணிப்பது, பிணியான உடைமாற்றாமலும், உண்ணாமலும் இரப்பர்
- ☐ எச்சில், சிறுநீர் மற்றும் மலத்தை அடக்கி வைப்பர்.
- ☐ கண்சிமிட்டவோ, அசையவோ மாட்டார்.

அறிகுறிகள்:- (உள்மந்தநிலை)

- ☐ ஒரு குறுகிய இடத்திற்குள், திரும்ப திரும்ப ஒரே மாதிரி செயல்களை அலுக்காமல் செய்துக் கொண்டிருப்பா.
- ☐ தான் கேட்கும் கற்பனை ஒலி அல்லது பார்க்கும் பயங்கர தோற்றத்தின் கட்டளைக் கிணங்க நடப்பர்.
- ☐ எதிரில் உள்ளவர்களை திடீரென தாக்குவர்.
- ☐ மற்ற மனச்சிதைவு பணியாளர்களை போல் உணர்ச்சி வசப்படுவர்.
- ☐ உறக்கம் இல்லாமலும், ஜன்னி போன்ற குழப்ப நிலையிலும் இருப்பர்.
- ☐ உடைகளை கிழித்து கொள்ளுதல், நிர்வாணமாக நிற்றல்
- ☐ அங்கசே'டைகள் செய்தல், முகம் சுளித்தல்.

சாதாரண மனச்சிதைவு
அறிகுறிகள்:-

- ☐ சந்தேகம், மாயபுலன் உணர்வுகள் காணப்படாது.
- ☐ மறைமுக அறிகுறிகளான சரிவர தன்னால் பேணாமை, சமூக வாழ்க்கையில் இருந்து விலகி எப்பொழுதும் தனிமையே விரும்புதல்.
- ☐ எந்த செயலிலும் விருப்பம் இல்லாமை
- ☐ இது மெதுவாக ஆரம்பித்து, தொடர்ந்து அதிகரிக்கும்.
- ☐ சில சமயங்களில் மனச்சிதைவு நோய் இயல்பாகவே குறையும் தன்மை கொண்டது.
- ☐ அது நாம் கோயில்களில் தங்க வைப்பதால் தான் குணமாகிறது என்று அந்த சமயத்தில் உங்களுக்கு தோன்றும்.

அமாவாசை, பௌர்ணமி போன்ற நாட்களில் மனச்சிதைவு நோய் அதிகரிக்குமா?

- ☐ நமது சமூகத்தில் அமாவாசை, பௌர்ணமி போன்ற நாட்களில் மனச்சிதைவுநோய் அதிகமாகும் என்ற கருத்து பரவலாக காணப்படுகிறது.
- ☐ இந்த காலகட்டத்தில் உறவினர்கள் மனநோயாளி என்றக் கண்ணோட்டத்திலும், நோய் அதிகரிக்கும் என்ற பார்ப்பதாலும்
- ☐ அவரின் இயல்பான செயல்களில் கூட அதிக மாற்றங்கள் ஏற்படுவது போல் இருக்கும்.

ஆரம்ப கால சிகிச்சையின் அவசியம்:-

- ☐ ஆரம்பத்தில் சிகிச்சை மேற்கொண்டால் நோயாளிக்கு சிகிச்சை அளிப்பது எளிது.
- ☐ குறைந்த அளவு மருந்து மாத்திரைகளில் குணம் மிக விரைவில் முழுமையாக கிடைக்கும்.
- ☐ ஆரம்ப காலத்திலேயே சிகிச்சை அளிப்பதாலும், குறைந்த அளவு மாத்திரைகளை பயன்படுத்துவதாலும், எந்தவித பக்கவிளைவும் ஏற்படாது.
- ☐ வியாதி முற்றிய பிறகு, தன்நிலை உணராது இருப்பர்.
- ☐ மருத்துவத்திற்கோ, மருந்துகளை சாப்பிடுவதற்கோ ஒத்துக் கொள்ளமாட்டார்.

மருத்துவ சிகிச்சை முறைகள்:

மனச்சிதைவு நோயினை குணமாக்க முடியுமா?

☐ ஆரம்ப கட்டத்திலேயே மனநல மருத்துவரிடம் குணப்படுத்த நவீன விஞ்ஞான ஆராய்ச்சிகளின் மூலம் பல புதிய மருந்துகள் தற்பொழுது உபயோகப்படுத்தப்படுகின்றன

- o மருத்துவ சிகிச்சை முறை
- o ECT எனப்படும் மின் அதிர்வு சிகிச்சை
- o மனவழி மருத்துவ ஆலோசனைகள்
- o தொழில் வழி மருத்துவம்.
- o மறுவாழ்வு சிகிச்சை முறை
- o ஆரம்ப கால சிகிச்சையின் அவசியம்.

மருத்துவ சிகிச்சை

ஆரம்ப காலக்கட்டத்தில் குளோர்பிரமஸின், ட்ரை.்பிளுபரஸின், ஹலோப்பேரிடால் போன்ற மருந்துகள் பயன்படுத்தப்பட்டது.

இவ்வகை மாத்திரை எக்ஸ்ட்ரா பிரிமிரடல் எனப்படும் பக்கவிளைவுகள்

- ☐ கைநெருக்கம், கை அசைவின்றி நடப்பது
- ☐ அதிகமாக உமிழ்நீர் சுரத்தல்
- ☐ திடீரென்று நாக்கு துருத்திக் கொள்வது
- ☐ மலச்சிக்கல், மாதவிலக்கு தாமதம்
- ☐ கழுத்து வளைந்து செல்வது
- ☐ நாக்கு குளறுவது
- ☐ உடல் உறுப்புகளை இறுக்கமாக வைத்திருப்பது.

இன்றைய புதிய கண்டுபிடிப்புகளை

- ☐ ரெஸ்ப்ரிடோன்
- ☐ ஓலன்சபின்
- ☐ க்யுடியாபின்
- ☐ அரிப்பிரசோல்
- ☐ ஜிப்ராஸிடோன்
- ☐ குளோஸிப்பின்

இம்மாத்திரைகளின் பக்கவிளைவுகள் மிக மிக குறைவு.

நு.ஊ.வு எனப்படும் மின் அதிர்வு சிகிச்சை

- ☐ மாத்திரைகள் நல்ல பலன் கிடைக்காத பட்சத்திலும், நோயாளிக்கு தற்கொலை எண்ணங்கள் அதிகமாக உள்ள போதும்,
- ☐ நாள்பட்ட நோய் குணமாகாத நோயாளியின் மூர்க்கத் தனத்தை கட்டுப்படுத்தவும்.
- ☐ அவசர சிகிச்சையாக மின் அதிர்வு சிகிச்சை கொடுக்கப்படுகிறது.
- ☐ மின் அதிர்வு சிகிச்சை முறையில் மிகக்குறைந்த அளவில் மின்சாரம் முன் மூளை பகுதியில் செலுத்தப்படுகிறது.

மனவழி மருத்துவ ஆலோசனைகள்:

□ நோயாளியின் உறவினர்களுக்கு வழங்கப்படுகிறது.

□ நோயாளியின் நோயின் தன்மைப்பற்றியும் அவரிடம் உறவினர்கள் எவ்வாறு நடந்து கொள்ள வேண்டும் என்றும் ஆலோசனைகள் வழங்கப்படுகிறது.

□ நோயாளியுடன் அன்பாகவும், ஆழமாகவும் பழகி அவர் சந்திக்கும் பிரச்சனைகளை எளிதாக சமாளிக்கவும் அல்லது அதன்மூலம் அவர் பாதிக்கப்படாத முறையில் அவரின் மனதை பக்குவப்படுத்தவும், மனவழி மருத்துவ ஆலோசனைக்ள் துணைபுரிகின்றன

தொழில் வழி மருத்துவம்

சிகிச்சை பெற்றுவரும் நோயாளிகள் சிறிது குணமடைந்த பின்பு அவருக்கு தெரிந்த தொழிலையோ அல்லது அவரால் செய்யக்கூடிய வேறு தொழிலை கற்று கொடுத்து அத்தொழிலில் ஈடுபட செய்வதே தொழில் மருத்துவம் ஆகும்.

மறுவாழ்வு சிகிச்சை முறை

□ முற்றிலும் குணமடையாதவர்கள் படிப்பிலோ, தொழிலிலோ, குடும்ப பொறுப்பை தாங்குவதாலோ, முந்தைய நிலையை அடைய மாட்டார்கள்.

□ இவர்கள் மனநல மருத்துவரின் உதவியுடன், தகுந்த மாறுதல்களை ஏற்படுத்தி சமுதாயத்தில் எப்படி செயல்படுவது மற்றவர்களுடன் எவ்வாறு பழகுவது எதிர்காலத்தை எப்படி எதிர்கொள்வது அல்லது பாதுகாக்கப்பட்ட தொழில் கூடங்களை நிறுவி அவர்களின் வாழ்வில் மறுமலர்ச்சியை ஏற்படுத்த பெரிதும் துணைபுரிகிறது

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APPENDIX-L

PHOTOGRAPHS

I. Researcher Collects Data from Subjects

II. Researcher Providing Psycho Education to Subjects

III. Researcher Taught Relaxation Technique to Subjecrts